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ROYAL COMMISSION ON HEALTH SERVICES

Proceedings of the hearings held in Toronto, Ontario, on the 1st day of May, 1962.

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ROYAL COMMISSION ON HEALTH SERVICES

Proceedings of the hearings
held in Toronto, Ontario,
on the 22nd day of May, 1962.

COMMISSION MEMBERS:

Chief Justice EMMETT M. HALL - Chairman

MISS ALICE GIRARD, R. N.

DR. C. L. STRACHAN

DR. ARTHUR F. VAN WART

MR. M. WALLACE McCUTCHEON, Q.C.

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COMMISSION COUNSEL:

MR. R. N.HALL, Q.C.

MEDICAL CONSULTANT:

DR. PIERRE JOBIN

DIRECTOR OF RESEARCH:

PROF.BERNARD BLISHEN

COMMISSION SECRETARY:

MR. N. LAFRANCE

---On resuming at 9:30 a.m.

THE SECRETARY: Mr. Chairman, the first submission this morning is the Canadian Red Cross Society. Their main submission, which is entitled "The Role of One Voluntary Organization in Canada's Health Services", will be exhibit 297; "Origin, Development and Future of the Canadian Red Cross Blood Transfusion Service,"the English version will be exhibit 297A, the French version of the same volume will be exhibit 297B, and their Consolidated Financial Statement 1961, will be exhibit 297C.

Mr. Shaw will introduce the delegation to the Commission.

---EXHIBIT NO. 297: Submission of Canadian Red Cross Society, "The Role of One Voluntary Organization in Canada's Health Services".

---EXHIBIT NO. 297A: "Origin, Development and Future of the Canadian Red Cross Blood Transfusion Service", English Version.

---EXHIBIT NO. 297B: "Origin, Development and Future of the Canadian Red Cross Blood Transfusion Service", French version.

---EXHIBIT NO. 297C: Consolidated Financial Statement, 1961.

SUBMISSION OF

THE CANADIAN RED CROSS SOCIETY

APPEARANCES: Mr. D. Bruce Shaw
Mr. Frank Hull
Dr. John T. Phair
Dr. W.S. Stanbury
Mr. W.E.C. Martin
Mr. Maxwell Bruce

MR. SHAW: Good morning, Mr. Chairman, distinguished members of this Commission. I am, as indicated, Bruce Shaw, national chairman of the Canadian Red Cross Society. I have with me this morning Mr. Frank Hull, Chairman of the National Executive Committe, Dr. John Phair, Honorary Adviser in Public Health, Chairman of the Technical Advisory Committee to the Blood Donors' Service, Blood Transfusion Service and also Chairman of the Junior Red Cross. Mr. Martin is the Honorary Treasurer of the National Society, and on the far right Mr. Maxwell Bruce, our Honorary Counsel. Last but by no means least our national commissioner, Dr. Stanbury, to whom we will be assigning a big part of these proceedings.

With your permission, sir, would you like me to open the presentation.

THE CHAIRMAN: Whatever way you wish to handle it, Mr. Shaw.

MR. SHAW: I do have a couple of little things I would like to say to the Commission before turning over the main work to our Commissioners. I want to say as the President of the Society how happy we are to have the opportunity of making a presentation to

you. We hope that it will prove constructive and useful to you in the task that you have set your hand to.

When we accepted the invitation to make the submission, Central Council of the Society instructed the National Officers that the job be as thoroughly done as it was possible to do it. We wanted it to be as comprehensive and as complete and certainly as accurate as careful painstaking research could possibly provide. We had no idea, I might say, at the early stages just how much painstaking research would be required, but it went forward.

The Canadian Red Cross, after the first war, when it accepted in common with other members of the legal Red Cross Societies, with the peace time role assigned to it, that is the improvement of health, prevention of disease and mitigation of suffering wherever it may be found, immediately assumed responsibility in the field of health services over a very wide front. At that time, as a voluntary agency, we pioneered new projects, the Society gave leadership in projects which are undertaken by others, and generally has been most active in the whole health field from that time forward.

We are grateful that the Commission has given us an opportunity to chronical the experience and achievements of the Society, because the research I have spoken of has covered what is new to most of us. I think we were quite impressed with what we found. We are indebted to our National Commissioner and to the senior members of his staff for the preparation that went into this submission, which consumed countless hours,

you. We hope that it will prove constructive and lead to you in the task that you have set yourselves to

When we accepted the invitation to join the association, national Council of the Society instructed the National Officers that this is as thoroughly done as it was possible to do it. We wanted it to be as comprehensive and as complete and as truly as accurate as careful planning research could possibly provide. We had no idea, I might say, at the early stages just how much painstaking research would be required, but it went forward.

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In the field of health services over a very wide front, at that time, as a voluntary agency, we pioneered new projects, the Society gave leadership in projects which are undertaken by others, and generally has been most active in the whole health field from that time forward.

We are grateful that the Commission has given us an opportunity to chronicle the experience and achievements of the Society, because the research I have spoken of has covered what is now to most of us I think we were quite impressed with what we found.

We are indebted to our National Commissioner and to the author members of his staff for the presentation that went from this association, which commanded courtesy, forms

what would otherwise have been leisure hours, but we are very proud with the finish product. We know it is going to be very valuable to the Red Cross; we hope it will be useful to you in your work.

Now, at this point, Mr. Chairman, I should like to ask Dr. Stanbury to present to you a summary of the submission and the recommendations that we are making.

THE CHAIRMAN: Dr. Stanbury?

DR. STANBURY: Mr. Chairman, members of the Royal Commission, as your Secretary has stated, we have two submissions, but for the moment I will confine myself to the summary and conclusions, The Role of One Voluntary Organization in Canada's Health Services. There is one chapter in this submission which is supplementary to that, the Origin, Development and Future of the Canadian Red Cross Blood Transfusion Service, namely, Chapter 15 of this submission, paragraphs 638 to 643, which brings the first document up to date.

SUMMARY OF MAIN CONCLUSIONS AND RECOMMENDATIONS

1. Need for the Voluntary Agency in the Health Services:

Since the beginning of time, all social progress has been made through man's desire to help his fellow man. That nation is greatest in which the greatest number of citizens assume self-imposed obligations for the common good. Voluntary organizations are the logical bodies through which these potentially powerful forces for the public weal can be channeled and employed. Governments will never be able to cover

the whole field of public health, nor is it desirable that they should do so.

2. Function of the Voluntary Agency in the Health Services:

(a) To be thoroughly familiar at all times with existing official and private services available in the health field; to stimulate and maintain interest in public health work and thus create the right climate of public opinion in order that necessary and desirable legislation may be enacted.

(b) To recognize the primary responsibility of government and establish a close relationship so that programmes can be operated in co-operation with the statutory authority or on its behalf when such is considered to be the most efficient and economical method.

(c) To ensure that its projects fill gaps in the publich health services and do not overlap activities already carried out by governmental or other voluntary agencies, so as to avoid duplication.

(d) To plan and conduct well-balanced programmes which could be continued within the framework of existing public health services.

(e) To experiment with new ideas and methods; initiate pilot programmes and demonstrate their value, and to turn them over to the official health services if and when this is appropriate.

(f) To ensure that all its programmes are conducted at such a high professional and technical level that they will serve as models and will deserve

the endorsation of the statutory authority and the support of the public.

3. Status of the Canadian Red Cross Society:

The Canadian Red Cross Soecity is a member of the International Red Cross. The formation and encouragement of National Red Cross Societies has been endorsed by the United Nations Organization. Each National Society has been recognized by its government as an auxiliary to the public health services.

4. Recommendations in Relation to the Canadian Red Cross Society:

The Canadian Red Cross Society believes it has demonstrated that this country needed and still needs the services it can contribute, and that its programmes are planned and conducted in such a manner that it performs the accepted function of the voluntary agency in the health services.

As a primary function of the Canadian Red Cross Society is to initiate and demonstrate new health programmes and to operate them in consultation with the statutory authority, it must always remain flexible. When the report of this Royal Commission on Health Services has been published, it may prove to be timely and desirable to turn over some Red Cross programmes to the official health services or to pioneer new ones. In the meantime, therefore, our recommendations which follow are, with few exceptions, of a general rather than a specific nature.

Since we believe that the Government of

Canada and the provincial governments recognize that the Society is performing a valuable role in the country's health services, we RECOMMEND that the statutory authorities use every means to keep before the public the desirability of continued and increased financial support of Red Cross work.

5. Veterans' Services;

All programmes for veterans have been initiated either at the request of or in collaboration with the Department of Veterans Affairs or its predecessors. All have been designed to improve the mental and/or physical health of the veteran and his family, and have been recognized by the Department of Veterans Affairs as accomplishing that purpose. Hospital visiting is done entirely by volunteers. The work in Lodges is almost entirely performed by volunteers; Lodges could not be operated by an official agency except at great expense and at the loss of the friendly atmosphere and extra services which volunteers can provide. The Arts and Crafts programme could be provided by the Department itself, but at greater expense due to the loss of volunteer participation. We RECOMMEND that all these programmes be continued as long as they perform their present useful function and as long as the Society has the means to support them. While no doubt there will always be need for a degree of individual emergency aid by a voluntary agency which provides 24-hour service, we trust the day will come when this can be limited to real emergency situations which arise on holidays and weekends when official agencies

are not available.

6. Junior Red Cross:

The Junior Red Cross has a three-fold objective: to improve the health and hygiene in the communities in which they live; to inculcate the idea of service to others, as a responsibility of citizenship, by providing incentive and suitable channels for social and community service; to foster international friendship and understanding. We RECOMMEND that the health and educational authorities use every means to strengthen and extend the Junior Red Cross within the educational systems.

7. Nursing Education:

The Canadian Red Cross Society pioneered the field of nursing education in this country by financing the establishment of public health nursing courses in five universities and, through the years, has enabled many nurses to obtain higher education by providing bursaries, scholarships and loans. Recently the Society has again pioneered by initiating the first Canadian fellowship for a nurse to study abroad at the doctoral level. We RECOMMEND that funds from other sources now be made available for nurses to pursue studies at the doctoral level and that eventually, when sufficient such personnel have been qualified, Canadian universities generally accept graduate study into their own curricula.

8. Dental Clinics:

The Canadian Red Cross Society contends that Red Cross dental clinics have long since demonstrated their value and that they are continued only to fill a gap

the two activity.

[illegible] Junior Red Cross

The Junior Red Cross has a three-fold objective: to improve the health and hygiene in the communities in which they live; to inculcate the idea of service to others, as a responsibility of citizenship, by providing creative and extensive channels for social and community service; to foster international friendship and understanding. We [illegible] that the health and educational authorities are every more to cooperation and extend the Junior Red Cross within the [illegible] schools.

[illegible] Health [illegible]

The Canadian Red Cross Society advocates the need of nursing education in this country by promoting the establishment of public health nursing courses in five universities and, through the years, has assisted many nurses to obtain higher education by [illegible] bursaries, scholarships and loans. Recently the Society has again sponsored by initiating the first [illegible] fellowship for a nurse to study abroad at the doctoral level. [illegible] ENCOURAGED that [illegible] from other sources may be more available for nurses to pursue [illegible] at the doctoral level and their eventually, when [illegible] such [illegible] have been qualified, [illegible] [illegible] [illegible] [illegible] [illegible] [illegible].

[illegible] Tuberculosis

that the Cross could. Nurses have long [illegible] [illegible] their [illegible] and that they are [illegible] only [illegible] [illegible]

in the public health services. We RECOMMEND that the municipal and provincial Departments of Health now assume this responsibility.

9. Outpost Nursing Stations:

The Canadian Red Cross Society believes that its outpost Nursing Stations are filling a need in frontier areas and that they will eventually be absorbed into health districts as such organized. As an interim measure, we RECOMMEND that adequate financial support be provided by all provincial Departments of Health.

10. Home Nursing:

Through Red Cross courses in Home Nursing, taught by professional nurses on a voluntary basis, Canadian women learn to become more skilled and resourceful in caring for the sick in their homes. This preparation also equips them to give efficient voluntary service in hospitals, child health centres, mobile chest x-ray surveys, prenatal education classes, crippled children's centres, as well as in Red Cross services. We RECOMMEND that this programme be endorsed on the basis that it provides valuable training, promotes a spirit of voluntary public service, is conducted on a high professional standard, at minimum expense, and prepares the family to receive the optimum benefits from any community health programme.

11. Sickroom Supply Loan Services:

The Red Cross Sickroom Supply Loan Service performs an important function in facilitating the care of patients in their own homes, but every year

it becomes more expensive and more difficult to administer on a strictly emergency basis. The Society believes it is logical to expect that the service might become an essential feature of any official home care programme. As a home care programme has not as yet been recognized as part of this country's official health services, we are not prepared at this time to make any specific recommendation with regard to the future role of the voluntary agency in the provision of this service.

12. Homemakers Service:

A homemakers service is an integral part of an adequate community health and welfare programme; there is a great unmet need for such services, which will probably increase; it is a community responsibility to provide such services whether under voluntary or public auspices; the care of the indigent and semi-indigent should be ensured by the municipal and provincial welfare authorities. We RECOMMEND that provision of homemakers service should be an integral part of any future prepaid or insured health plan, whether under public or voluntary auspices.

13. Blood Transfusion Service:

The Canadian Red Cross Blood Transfusion Service has been said to be "the most ambitious publich health programme every undertaken by a voluntary organization anywhere". It has now attained national coverage. The Canadian Red Cross Society believes that it is uniquely equipped to operate and administer a national blood transfusion service based

It becomes more expensive and more difficult to carry out on a strictly elsewhere basis. The society believes it is logical to expect that the serving might become an essential feature of any official home care programme. As a home care programme has not as yet been recommended as part of this country's official health services, we are not concerned at this time to make any specific recommendation with regard to the future role of the voluntary agency in the provision of this service.

12. Homemakers Service:

A homemakers service is an important part of an adequate community health and welfare programme; there is a great unmet need for such services, which will probably increase; it is a community responsibility to provide such services whether through voluntary or public agencies; the core of the trained and semi-trained staff is provided by the municipal and provincial welfare authorities. We recommend that provision of homemakers service should be an integral part of any large hospital or insured health plan, whether under public or voluntary auspices.

13. Mental Health Services:

The Canadian Mental Health Association Toronto has been said to be the most active public health agency promoting early treatment by a voluntary organization anywhere. It has the attitude of mental hygiene. The association feels strongly believes that it is necessary and to operate and maintain a mental health service open

on the voluntary principle. We RECOMMEND that the national Blood Transfusion Service in all its aspects should continue to be operated and administered by the Canadian Red Cross Society with adequate financial assistance from the federal and provincial governments.

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McH/dpw

THE CHAIRMAN: Thank you very much, Dr. Stanbury.

In perusing this document, which is a large one, we can see that really the philosophic discussion and justification for the voluntary agencies and societies are well known as well as covering the philosophy of Red Cross. We have had submissions from many voluntary organizations and agencies but no other agency has delved as deeply into the history and development of the voluntary agency as Red Cross has done. We are indebted, Mr. Shaw and gentlemen, to the Red Cross for what has been done here.

It is not unbecoming that the Red Cross should have done this because it is, by far, the largest voluntary organization in the world and has very active branches and organizations in all countries including the countries on both sides of the Iron Curtain and, through the means of the Red Crescent, of the Islamic countries as well. We accept this brief as containing the principles upon which voluntary organizations did come into being and upon which they may or ought to continue in the future.

This summary is a very condensed one and perhaps it might be as well if we did have some expansion of this question of the blood transfusion services, just what function it now performs and particularly what the Red Cross sees for the future in the event that there comes into being in Canada some form of national or national and provincial health service on a prepaid basis in whatever form it may take. The

question is not being predicated upon any particular plan but just opening up the subject in a general way, having in mind and recognizing the trend of the times that something may well come into being, where will the Red Cross fit into that picture?

MR. SHAW: I will take a crack at that. No one is any better equipped to talk on this whole broad field than our National Commissioner, perhaps because of a little narrower range of intimacy with the whole field of the blood transfusion service because it is a vast one.

I might make a few personal comments; first of all, I would say this is a subject that has engaged the attention of our governing body, the Central Council, at great length and we have had many serious discussions about it. The policy we have established at the moment is pretty well contained in the clause that Dr. Stanbury read to you having to do with the blood transfusion service. This is broken down into two parts, the technical end and the procurement end.

The procurement end is the gathering together of the donors, the extraction of the blood from them and the organization that will keep the blood of donors coming forward to the extent required that will permit the Society to meet, as it has done so far, its claim that free blood is available now to any hospital anywhere in Canada in any quantity that may be required. That places a great stress and strain on our donor procurement service and they are constantly

on the edge of endangering the validity of that claim. However, we think we can continue to do it; that is the donor end. I think I can speak for the Society here when I say that the donor end of it with all its aspects should continue to be the sole responsibility of a voluntary organization and we believe the voluntary organization should be the Canadian Red Cross Society.

THE CHAIRMAN: Just on this point, are you able to give some estimate of the number of volunteers engaged in this donor procurement program across the country?

MR. SHAW: Dr. Stanbury, could you pull that figure? I can tell you, I think I would be on safe ground in giving you the number of bottles - perhaps Dr. Stanbury could give it to you accurately.

DR. STANBURY: Quite apart from the volunteer donors themselves, which are the largest group of volunteers ---

THE CHAIRMAN: I am talking about those who organize and perform the work.

DR. STANBURY: In addition to the volunteer donors which last year numbered 679,300, we have large groups engaged in the recruitment of volunteers, the operating of telephone services and so on. It is very difficult to estimate the number but if we take the Toronto branch as one single example, there are some 1,100 people actively engaged, week after week, in the recruitment of volunteers, using the telephones and driving trucks and that type of thing.

Another example is our women's work

2 committees which make or send goods for international relief, prepare all the surgical material amounting to over 6 million pieces last year. We estimate this alone saved the Society some $37,000. The Junior Red Cross is similarly active in that field of preparing surgical dressings and their numbers are in the millions.

I think it would not be too far afield to state that possibly several hundreds of thousands of people are directly or indirectly engaged in the blood transfusion service quite apart from the almost 700,000 volunteer blood donors.

MR. SHAW: Is that an adequate answer to the question? Moving to the other phase of this service, the technical end ---

THE CHAIRMAN: That phase of it; the Red Cross takes care of the cost of the whole operation of the procurement service - is Red Cross responsibility?

MR. SHAW: We have done and believe we should continue to find the funds to completely finance the procurement end of the blood transfusion service.

Then we move into the technical end. The part of the organization responsible for the handling of the blood once taken, the testing, the classification, the storage, the transportation, the cross-matching, everything that goes into the handling of ---

DR. STANBURY: The technical side does include taking of the blood, that is a professional service.

MR. SHAW: You see the distinction Dr. Stanbury is making; that the donor procurement people get the bodies to the clinics but immediately anything is done along the medical treatment line they become a responsibility of the technical end, the drawing of the blood and that sort of thing. In that end of the service it is there that we run into substantial expense, therefore, we cannot rely on volunteers. There we must be sure that we have thoroughly qualified technical people and professional people looking after that phase of the service. The wisdom of that policy has been proven in the records so far from a professional point of view and from the record of safety, if you like, that has been very high indeed.

The point I want to make here is that here we get into a cost and relatively low voluntary participation; there is voluntary participation but it is here that the large part of our expense develops and it is in this area that we have had to develop our relationship with governments as to assistance. Initially, as the brief will point out, as the service began to become countrywide, we had to establish a formula to get going on. Originally we had a formula where we asked the Provincial Governments through their Hospital Insurance Commissions or whatever the agency involved might be for 30% of the technical cost. That was a test, if you like, and we operated under that for a number of years. That 30% continued but proved to be inadequate, the service therefore creating too severe a strain on our funds and endangering our other programs.

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[illegible] [illegible] the [illegible] [illegible]

[illegible] turn by [illegible] that the [illegible] requirement [illegible] the [illegible] to the [illegible] it immediately [illegible] is done [illegible] the medical [illegible] they [illegible] a responsibility of the technical end, the [illegible] of the [illegible] that most of this. In that [illegible] of the [illegible] it is there that we [illegible] into the [illegible], therefore, we cannot rely on volunteers [illegible] we must be sure that we have thoroughly [illegible] technical [illegible] and nontechnical people [illegible] the [illegible] of the service. The wisdom of that policy has been proven in the records [illegible] from a professional point of view and from the point of safety, if you like, that has been very high [illegible].

[illegible] I want to make here is that [illegible] we [illegible] relatively low volunteer [illegible] at [illegible] the [illegible] of our extreme levels [illegible] that we have had to [illegible] with [illegible] as to [illegible]. Initially, to the [illegible], as the service began to [illegible] to establish a [illegible] to [illegible] we [illegible] where we [illegible] the [illegible] through [illegible] the [illegible] would be [illegible] technical [illegible]. That was [illegible], if you like, and we [illegible] that [illegible] the [illegible], [illegible] for [illegible] a [illegible] other [illegible].

Within the last two years we initiated a fresh approach to the Provincial Governments and the Federal Government. Through matching grants arrangements now with the provincial contribution to match equally with the federal contribution and we have succeeded in getting the province's acceptance, province and Federal Government's acceptance of a new formula which from this point forward will involve the payment by government of 60% of technical cost and the Society picking up the 40%.

/C/ss

MR. SHAW: The point we would like to emphasize here is that 60% wasn't an accidental figure. It is our philosophy, rightly or wrongly, as long as this is to be known as a voluntary blood transfusion service the Society should somehow finance more than half the total cost, and the 60% of the technical cost works out to a result that the Government would contribute about 48 and one-half per cent of the overall cost, donor and technical together with the Society picking up just over 50%, 51%. We are getting into decimals here. This is our philosophy at the moment, and our policy is then we feel if this is to be a voluntary operation that we must not let the Government get in the position of paying more than a percentage of the cost. We think more than 50% of the cost might be dangerous. That is our present philosophy. Does that carry your understanding, Dr. Stanbury? Have I put that correctly.

DR. STANBURY: There is a legal precedent to this as far as the meaning of voluntary aid society within the meaning and context of Article 10 of the first Geneva convention. The Society asked for a ruling on this matter during World War II and Mr. Justice Reid, who was then legal advisor to the Department of External Affairs said the Society would never be endangered in its rights as a voluntary aid society within the context of the Geneva convention as long as Governments weren't paying extraordinary amounts toward the total cost. In other words, that is, as long as the Society continued to bear the major portion of the cost its status under the Geneva convention would be assured. There is a

Mr. [illegible]: Mr. Chairman, we would like to [illegible] one is that [illegible] a problematical figure. It is [illegible] economy, [illegible] or [illegible], [illegible] as this is to be known as a voluntary blood [illegible] service [illegible] a [illegible] below [illegible] than half the total cost, and [illegible] of the [illegible] [illegible] to a [illegible] that the Government would contribute [illegible] as [illegible] [illegible] part of the overall cost, donor and [illegible] [illegible] with the Society placing [illegible] that [illegible] [illegible], [illegible] we are getting into [illegible] [illegible] is our philosophy at the moment, and our policy [illegible] then we treat it this is to be a voluntary organization [illegible] there is [illegible] not let the Government get in the position of [illegible] more than a [illegible] or the [illegible]. We think [illegible] than 50% of the cost [illegible] be [illegible]. That is our present philosophy. Does that carry your understanding, Mr. Chairman? I put that correctly.

Mr. Chairman: There is a legal problem [illegible] to this as far as the meaning of voluntary aid society within the meaning and context of Article 10 of the First Geneva Convention. The Society asked for a ruling on this matter during [illegible] Mr. Justice Fair, who was then [illegible] adviser to the Department of External Affairs [illegible]. The Society would [illegible] in its rights as a voluntary aid society [illegible] [illegible] of the [illegible] [illegible] as long as Government [illegible] paying extraordinary [illegible] [illegible] cost. In other words, then [illegible], as long as the Society [illegible] to keep the [illegible] [illegible] the Geneva Convention would be [illegible]. There is a

bit of a legal precedent to this. Chapter 16 gives details, Chapter 16 does give details of the financial support in actual amounts both for the year ended 31st December 1961 and the budgeted amount for the current calendar year.

THE CHAIRMAN: In round figures what does the overall transfusion service cost, in round figures what is it?

DR. STANBURY: The gross cost in 1961 was $3,545,941.00 and the technical cost is $2,683,526.00 from which we recovered from the Hospital Insurance Commission as a facility under the Hospital Insurance Plan $1,362,994.00. This was an increase over the preceding year as will be indicated from our comparative statement of over $500,000.00.

THE CHAIRMAN: That is the first year that the transfusion service blanketed the country completely.

DR. STANBURY: Yes, sir. That was a windfall in the sense we had no right to anticipate this additional 15% when the budget was prepared in November, 1960, so therefore, we have a windfall of some $411,000.00 in this particular year that will be non-recurrent in the future.

THE CHAIRMAN: In the international work, Mr. Shaw, in which the Canadian Red Cross has participated very actively for a period of years, where does the finances for the international work come from or where have they come from, where do you expect they will come from in the future?

MR. SHAW: The answer to that is important. I think it should be quite accurate. I think Dr. Stanbury has the document in front of him which he might, if you would like, refer to. I would simply say up until 1960, the Society had virtually no money in the budget for international relief work as such apart from the Women's Work and so on. We were in unusual circumstances permitting us to finance without drawing on the public, which I would like Dr. Stanbury to recount to you.

DR. STANBURY: Mr. Chairman, if you will kindly refer to our consolidated schedule of designated and reserved funds you will see under International Relief a fund entitled International Relief Fund. The origin of that was in the European Flood Relief Fund effort of 1953 and a special committee was created under the chairmanship of His Excellency the Governor General of Canada that raised funds for the relief of the victims of the great floods of Great Britain, the Netherlands and Belgium. To that fund the Government of Canada contributed $1,000,000.00. Some $3,105,100.00 were accumulated. At the suggestion of the then Prime Minister of Canada the Canadian Red Cross Society was designated as the administrative arm of the European Flood Relief Committee.

MR. SHAW: May I interject, you mentioned the Federal contribution, would you explain the others?

DR. STANBURY: Yes. Of the $3,105,000.00 the Federal Government contributed $1,000,000.00. The Provincial Governments contributed $323,000.00 and the

rest was raised from the public, $1,782,700.00. When all the disbursements had been made for the rehabilitation of the people of Great Britain, the Netherlands and Belgium, the unexpended surplus was in the neighbourhood of $649,000.00. We appealed to the Prime Minister of Canada as to how we could be relieved of the stewardship as regarding this fund. At his suggestion the Act was put through the House of Commons undesignating those funds and creating what we now call the International Relief Fund. The Provinces were similarly canvassed and raised no objection to that, although no legislation was passed. Our main source for international relief since 1954 has been this fund. An average of $135,000.00 has been spent annually, excepting special projects such as the Hungarian refugee relief period. Otherwise it has been an average of around $135,000.00. At the close of the year you will note that approximately $43,900.00 is left in this fund but already in 1962 we have had major calls on it; Yugoslavia, the hurricane in Morocco, and most recently the provision of medical teams, traffic and other personnel for the repatriation of the Algerian refugee children in Tunisia and Morocco. At the present time we have two sets of medical teams, one doctor, two nurses, two traffic men and an organizer. Nine personnel are in Algeria and we still have one man in the Congo dealing with the reorganization of the Congolese Red Cross in cooperation with UNESCO in the distribution of the milk programs for pregnant women and under-nourished children. We have, as you will see from this schedule a number of designated funds which we undertake to administer,

Stanbury

We have a long history in that respect and the most recent one last year was the British Honduras Hurricane Relief Fund of 1961 which was undertaken --- the fund-raising was undertaken by a special committee under the chairmanship of Mr. Earl McLaughlin, President of the Royal Bank of Canada. This was successful, the committee raised approximately $120,000.00. That is typical of the many designated funds we undertake to administer at no cost whatsoever to the fund. Of course, we are trustees in the strictest sense in relation to these funds. These are not our own funds, such as the British Honduras or the Greek Earthquake.

MR. SHAW: It should, perhaps, be underlined here that this set of circumstances that did provide the source of funds to us--those have now been virtually all expended. We have, the Canadian Red Cross Society has created for itself an enviable standing in the world because of the contributions it has been able to make, not only in people, but having had the financial resources to undertake them. We will be faced with the necessity of finding some alternate source of funds when this $43,000.00 that appears here ...

DR. STANBURY: There is only $23,000.00.

MR. SHAW: It is down to $23,000.00 and we are faced with the necessity of carrying into our campaign the problems and responsibilities of budgeting for international relief.

THE CHAIRMAN: By and large you will have to get that money through your campaign fund, I take it?

MR. SHAW: That is right.

DR. STANBURY: I don't think we should forget to mention the very large contributions made to us by two groups of volunteers, our Women's Work Committee and our Junior Red Cross. Virtually the whole expenditure for the Women's Work Committee are shown on these schedules, $332,964.00 is for raw materials only so the value of the relief supply in made up clothing and bedding would certainly be three or four times that amount. Similarly the Junior Red Cross has contributed in recent years something in the neighbourhood of $180,000.00 for international relief. That is quite apart from the $135,000.00 I mentioned.

THE CHAIRMAN: Then, on the domestic scene you spoke of pilot projects in various health fields. What is the situation at the present time in regard to those pilot projects?

MR. SHAW: I suppose the most interesting one is the one just now completed in Alberta. Would you like to speak to that?

DR. STANBURY: Of course, in a sense, our greatest pilot project of recent history has been the blood transfusion service. I think, Mr. Chairman, what you may be referring to is the Grand Prairie Pilot Project in Paragraph 526 to 534. We are aware, of course, that various home care programs have been studied here in Toronto and Western Canada, some primary work has been done in Wellington County, but this one is rather unique in that it is attempting to study the philosophy of home

care in what might be called the frontier area of Canada, that is the area that has certain urban elements as well as rural elements, the Peace River block of the Province of Alberta. This program is now in the stage where it is ready to be reported on in the very near future.

THE CHAIRMAN: When that report becomes available, may we have it?

DR. STANBURY: Certainly. It is a closely integrated program with the Department of Health of Alberta with facilities that are available locally, no new programs are being introduced. It is a matter of utilizing what is available in the area, and therefore it is heavily concentrated on home nursing programs and sick room supply loans all of which is professionally supervised by the health group and the medical advisor of health.

MR. SHAW: May I add one other example, Dr. Phair just reminded me, one of our most interesting pilot projects in the nursing field in training of nurses was what we refer to as the Windsor Project where the Red Cross financed for a period of four years for the cost of $40,000.00, total cost of $160,000.00 an experiment into qualifying nurses over a two-year period instead of a three-year period. That is covered in our brief, but it is a very interesting venture and we hope to find now that the lessons we learned there are being put into practice and are becoming very useful indeed in the project here in connection with the University of Toronto.

G/dpw

THE CHAIRMAN: Perhaps Dr. Strachan and the members of the Commission would be interested in the pilot dental project in Northern Saskatchewan?

DR. STANBURY: Mr. Chairman, that is a Junior Red Cross project, and it will be found in Chapter VII, paragraph 298, pages 87 and 88. In this, Mr. Chairman, the Department of Health were concerned as to the dental health of native children in the northern part of the province, which were without any dental care whatsoever, so the Junior Red Cross of the Saskatchewan Division concentrated on providing two travelling dental clinics, two each year, at both Cumberland House and Ile a la Crosse.

Now, this project is in its final year, but already the regular dental attention of these many children, the importance of regular dental attention, has been amply demonstrated, and the Junior Red Cross of the Saskatchewan Division have submitted the details of the pilot project to the Department of Health, with a recommendation that a permanent dentist should be appointed for northern Saskatchewan, who could visit centres, such as the two I have mentioned, twice yearly and that would be a tremendous contribution to the dental health of the people in that province.

That has been done to date at a relatively low cost of $9,042 per year, but that is not actually the real cost, because at least five of the clinics, of the 15 that were performed in the first two years, were made possible by the voluntary services of dentists.

There are quite a number of projects in that section dealing with dental care under Junior Red Cross, but this is one of the more recent and very interesting ones.

COMMISSIONER STRACHAN: Is there any demand for this service from other provinces in similar areas?

DR. STANBURY: Yes sir, we have got a very big program in Ontario, travelling dental clinics are covered on page 84, paragraphs 278 to 282.

At the present time the Junior Red Cross is supporting three dental coaches, which travel in Northern Ontario in areas not served by a resident dentist. In 1957, the cost of these coaches was over $18,000 but by 1961 it reached a total of $31,605.

Now, as we have mentioned in our summary and conclusions, we are a little concerned at the mounting costs to the Junior Red Cross each year of the various dental projects, particularly as we believe that the need has already been established, and the method of handling the need has also been established.

For example, in the past two years, the cost of dental services defrayed by Junior Red Cross has varied from anything between 79,000 to 83,000 dollars per year of Junior Red Cross funds, which are, of course, designated funds raised by the children themselves in the school and are quite separate from the funds of the senior Society.

I might add that the senior Society

pays all the administrative costs of the Junior Red Cross and the funds raised by the children themselves go to the specific projects.

COMMISSIONER STRACHAN: Do you get any aid from the Departments of Health of the various provinces in these projects?

DR. STANBURY: No sir, these are considered pilot projects. We have been urging that they be taken over in whole or in part, and under the Montreal Dental Clinic Study you will see that some progress has been made in that regard. The City of Montreal Department of Health has gradually taken over some of the clinics, but we don't think that in a city such as Montreal that Junior Red Cross funds should continue to be spent for this purpose, when it is surely the legitimate responsibility of the public health authorities, or the educational authorities, to look after the dentally indigent children.

COMMISSIONER BALTZAN: For the most part the preventive dental services, as I note here, were apparently donated by the dental profession?

DR. STANBURY: You are speaking of the Saskatchewan project?

COMMISSIONER BALTZAN: Yes.

DR. STANBURY: Yes, at five of the fifteen clinics under review, the dentists gave their services voluntarily, but generally speaking, these projects are done by a salaried dentist. The equipment has been donated. The best examples are the rural dental clinics in Quebec. The supply houses in Montreal donated the chairs, lights and other equipment. The

Department of National Defence has provided the dental kits for the summer.

That rural project in the Province of Quebec, unlike the Montreal City project, is very, very inexpensive indeed.

COMMISSIONER GIRARD: Mr. Chairman, I would like to take this occasion to pay a very special tribute to the Canadian Red Cross Society for the splendid assistance it has given the nursing profession throughout the years. This has been mentioned this morning, and I would like to mention it again in the field of nursing education, nursing services, public health nursing, bursaries, loans. I don't believe there is any phase of nursing that has not been helped tremendously by the Red Cross Society, and I hope this will continue in the future.

For a more practical question, I would also like to know if there are any difficulties in maintaining the outpost clinics in the provinces? I am thinking now particularly of the Province of Quebec. I remember at the onset of the Hospital Insurance in the province we had some fears of losing the Red Cross outposts. Has this been arranged since?

DR. STANBURY: At the moment, Madam Commissioner, there are three outpost nursing stations being maintained by the Quebec Division. Those, as you know, have always been concentrated in the Magdalene Islands or the Gaspé Peninsula. Three are active at the present time. In the overall picture, 24 nursing stations, 8 in British Columbia, 6 in New Brunswick,

7 in Ontario, 3 in Quebec, 2 in Saskatchewan as well as 17 outpost hospitals in Ontario, which continue to be operated by the Ontario Division at the request of the Ontario Hospital Services Commission.

But the hospitals, unlike the nursing stations, are completely financed by the Commission. There are difficulties from time to time in recruiting staff, but I think that we have been remarkably successful in this regard. The outpost hospitals, at the present time in Ontario, employ 56 registered nurses, and the nursing stations, 26 registered nurses. All the posts are filled at the present time.

COMMISSIONER GIRARD: When you mentioned that the outposts have been assisted by the Government Hospital Commissions, they still retain their voluntary character, of voluntary agency, do they not?

DR. STANBURY: They do, Miss Girard. This is a service really, essentially, as far as the hospitals are concerned in Ontario, that is being continued by the Ontario Division. We have no cost with respect to that. There is a great deal of voluntary service in preparation of the supplies, and that type of thing, but fortunately, we have been relieved of a very major cost in the operation of hospitals in Ontario. This, presumably, is only a temporary measure, until the communities can take over the administration of the hospitals in their own communities.

On the other hand, with respect to the nursing stations, where the nurse is not necessarily

tied to a bed, as it were, we are receiving financial assistance from British Columbia and Saskatchewan only in any great degree, and in Ontario and Quebec no financial assistance from governments. That is entirely supported by a small amount of fees, which is very small indeed, and campaignthe funds of the Red Cross Society.

COMMISSIONER GIRARD: How difficult is it to recruit nurses for outposts, or how easy?

DR. STANBRRY: Miss MacArthur should answer that question if she is here.

THE CHAIRMAN: Miss MacArthur?

MISS MacARTHUR: Mr. Chairman, it is as difficult as to recruit in many areas, because there are just not enough nurses to go round, but we have been very fortunate in Canada in having nurses who wish to do pioneer work. Those who like to go to the frontiers of Canada go, and stay with us. So, on the one hand we have a great strength; on the other hand, we have the problem of competing with other parts of the country and also of competing with salary levels, which are not always possible in the structure of voluntary agencies, such as industry.

COMMISSIONER GIRARD: Thank you very much, Miss MacArthur.

COMMISSIONER FIRESTONE: Mr. Bruce, Dr. Stanbury and gentlemen, if I may come back to Recommendation No. 8 on page VI, dealing with dental clinics. You say, and I quote:

"We recommend that municipal and

provincial Departments of Health now assume this responsibility."

I gather you are most active in the Provinces of Ontario and Quebec. My question is, have you approached these provincial governments to take on this responsibility, and if you have, what answer have you received?

DR. STANBURY: Yes, Mr. Chairman, this matter has been kept before the provincial authorities constantly and there has been some progress made, as I indicated, in respect to the clinics in the City of Montreal, but as far as I know very little or nothing as far as the Province of Ontario is concerned.

As we say in paragraph 302 and in Chapter VII, we feel that the need has been amply demonstrated and the method of handling these indigent cases which are living remote, the method has been established and could be carried on by the official authorities.

DR. PHAIR: Speaking for the Province of Ontario, the provincial authority, health authority, has operated for about 15 years cars, two of them, one in the northern part, extremely north, and one on the Canadian National and one on the C.P.R. The one in northern Ontario covers a bit of both. The railway companies are most co-operative in trying to meet the need for dental care, which originally was limited to children; they even have had on occasion maintained the coach.

The dentist and his associate, if the associate is a female, she is his wife. You can understand in a project of this kind an enormous amount of time and effort is expended on the clerical aspects of it. So there are usually a young dentist and his wife. They have been operated by a dentist alone. They have on occasion -- and I don't think the occasions are rare, ever rare -- have dental emergency in the area in which they are operating. I think everyone here is appreciative of the fact that expansion of state intervention in dentistry is as much a concern to organized dentistry as expansion in the medical field is to organized medicine. These are operated by salaried individuals and difficult, naturally, to provide

staff all the time. But the program has been well-accepted; they run along the railroad lines and stop at crossroads and they run on schedule. It has been a state-operated project for which I don't think there is too much in the way of a similar character anywhere.

I might add here, Mr. Chairman, that a project in the field of community dental service, particularly directed children, was operated for some five years in the Province of Newfoundland -- four years to be exact -- and ultimately taken over, as the result of the Red Cross, by the Province.

COMMISSIONER FIRESTONE: Did I understand you correctly, and if I didn't please correct me, that if this project of providing dental care for the needy in outlying areas were taken over by the provincial government from the Red Cross which operates it at the present time there might be objections to such a take-over from the dental profession?

THE CHAIRMAN: I think Dr. Phair told us that the province was now administering the service.

DR. STANBURY: There are two services. That is the confusion, I think.

THE CHAIRMAN: Because this railway service you are speaking of is a provincial service now?

DR. PHAIR: Yes. The service in Temiskaming, northern Ontario, where a dentist was situated.

THE CHAIRMAN: It was whether there was any philosophic objection being forthcoming.

DR. STANBURY: Of course, in Ontario this is operated under the Dental Committee and the ground rules are fairly well laid out to avoid any criticism from organized dentistry. These mobile coaches are not supposed to operated within the radius of 15 miles of a resident dentist. This matter is reviewed constantly by the dental committee which represents the dental profession.

COMMISSIONER FIRESTONE: We would therefore not expect any objections from the dental profession if the recommendation you have made in paragraph 8 were implemented, which is provincial and municipal departments of health carrying it out?

DR. STANBURY: Not in respect to those travelling clinics, as long as the ground rules are observed.

COMMISSIONER FIRESTONE: What are the reasons as to why the Ontario Government and the Government of the Province of Quebec have not as yet taken over this program and are relying on the Red Cross to continue to operate when you feel the time has come when they should take it over?

DR. STANBURY: I think Dr. Phair might answer that.

DR. PHAIR: Actually the provincial Department of Health in the Province of Ontario did operate a summer service comparable to what is now presently being operated by the Red Cross Society in the areas which were not included in those served by the railway coaches and backed out of it for one reason and

only reason really, and that was we couldn't get staff to operate. They were operated during four months of the year, and even the young dentist, recent graduate, is not interested in spending four or five years in this kind of service. It is primarily a matter of recruitment of staff and for which we, the Department of Health at that time discontinued, that is operating in a motor-driven vehicle.

COMMISSIONER BALTZAN: If these vehicles came within 15 miles of a dentist, would there be sufficient work to retain a dentist in these out-posts?

DR. PHAIR: For the time being, for the initial, perhaps, one or two years, the answer would be yes. But you can appreciate that the cost spread over a large area, at least the service spread over such a large area, in order to meet the ground rules, as Dr. Stanbury called them, it became prohibitive in terms of the provincial Department of Health.

MR. SHAW: I wonder if I might try it. I think what Commissioner Firestone was getting at, have we asked the Government, do we know why they haven't produced some money? I think you and Dr. Phair, Dr. Firestone, have something in common. Dr. Phair is talking from intimate knowledge, because he was Deputy Minister of Health for the Province of Ontario, and he comes to us with that experience to help us in the many other things he does for the Red Cross. You keep hammering away and eventually these things are done, but why they are not done as soon as we ask them is something we don't have any answers on.

Usually these things are well-documented, but the existing policy may stand in the way of acceding, if you like, to the suggestion we make along the way.

We carry on these pilot projects in the hope that they will cease to be pilot projects, that somebody will take them over and we move into other things. For that reason we wouldn't want continuing government help because we would become part of it.

COMMISSIONER FIRESTONE: You have a very sound principle: You develop a service, the need has been substantiated, the method has been proven, you then go to the government and ask them to take it over. But if you can't get the principle to work, if you are asking the government to take something over which is beyond the powers of the government, the question is: Why is this thing not being taken over?

MR. SHAW: Perhaps I could draw a bit of an analogy here. When we were in the out-post hospitals field in a big way the theory there was we would establish a hospital in the community until the community has developed to a degree that they could take it over and we would turn over the plant and say there is everything, it is yours, run it. Now, that did happen at various speeds in varying parts of the country. But when we had provincial health insurance schemes come along and when hospital deficits became no longer the thing that prevented this taking place, we handed over hospitals in the community except in the areas where we were asked to continue, except at no cost,

no drain.

In these pilot projects we cannot determine the time when we step away from them. We continue and we hope that when the time is appropriate for someone to take them off our hands they will do so, but you can't put a time-table on it.

COMMISSIONER FIRESTONE: There was one point and that was the problem of staffing by provincial governments. Now, if the Red Cross is able to obtain people for such a program, why not the provincial government?

MR. SHAW: The provincial government has succeeded in getting staff to run these two coaches; they are running. Perhaps we are fortunate in that, as stated by the Director of our Nursing Services, there is an attraction in working for a Society like the Red Cross that sometimes governments are not able to offer.

COMMISSIONER FIRESTONE: Thank you very much, Mr. Shaw.

May I now turn to paragraph 610 and following paragraphs on page 190 in which you give us the results of a school meal study which has been undertaken by the Red Cross over a period of two years and which has turned out to be a monumental piece of survey and research work. I am just wondering, sir, whether you and your associates may offer some advice as the result of this school meal study that you have undertaken. Would you say that there would be some merit in developing a program for school children of providing (a) milk at school, (b) orange juice and

(c) vitamins?

MR. STANBURY: Mr. Chairman, I think the school meal study is an excellent example where you get a negative result to what has been anticipated. Prior to the Society undertaking the school meal study under the directorship of the late Dr. Tisdale in 1946, it was generally believe that the school meal had great merit. As Dr. Tisdale pointed out at that time, in the United States they were spending as much as $93 million annually to provide school luncheons, in Great Britain something in a similar neighbourhood.

Now, what Dr. Tisdale and his group have definitely established is that the school meal is of limited value when you have a controlled group. It is suprising perhaps that both the United States and United Kingdom expended these vast sums on a school luncheon program without undertaking a study to see if it has any value. The value is negligible, if it has any value at all, as Dr. Tisdale indicated. This school meal study was published by the Society and, strangely enough, many years after is still very much in demand by universities and colleges from all over the world. This is the first basic study of value on a particular program. The fact that it has negative results is equally important; it may have saved the treasury millions of dollars.

THE CHAIRMAN: Is there a copy which may be available to us?

DR. STANBURY: Yes.

COMMISSIONER FIRESTONE: Would you say,

sir, based on this particular study, there was little merit in your opinion of providing milk free to school children, free orange juice and vitamins?

DR. STANBURY: Yes, I think so, sir.

COMMISSIONER FIRESTONE: Thank you very much.

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COMMISSIONER BALTZAN: I have no questions, but I do want to state that for me personally and I am sure the members of the Commission there are two very positive statements that certainly have helped us a good deal in relation to these two matters and they have come up frequently in our discussions across the country. I should like to requote again the comments I refer to:

> "Governments will never be able to cover the whole field of public health, nor is it desirable that they should do so."

We have faced that sort of question several times and you gave us a very positive answer.

I am also very grateful to you for helping me out in my own thinking in respect to you say:

> "...we recommend that the statutory authorities use every means to keep before the public the desirability of continued and increased financial support of Red Cross work."

Perhaps as the last question, what is the likelihood of your being able to make or very successfully operate such as you have demonstrated over the years in the future when perhaps your activities are a little curtailed? What is the future in the way of making voluntary contributions?

MR. SHAW: I wonder if Mr. Hull might answer.

MR. HULL: It is not an easy question to answer, but I would suggest there is always sufficient in the programs of Red Cross to interest the voluntary

donation from the public at large. We have proved this a good many times. We have gone from various programs to other programs, from blood transfusion to the swimming and water safety and so on. There are always new pilot projects which seem to capture the imagination of the public. We have our troubles in our campaign but basically I think the Red Cross will be supported by the public at large.

COMMISSIONER BALTZAN: A most encouraging statement.

MR. HULL: I may be out of order, but I would like to thank Miss Girard for the very kind remark she made about our nursing service, because we are very proud of it.

COMMISSIONER STRACHAN: I have no desire to turn this into a dental brief,but I am sure many of us are aware of the work done in the cleft palate and research treatment centre of the Hospital for Sick Children and Red Cross has given much towards this project. Do you see any possibility or is there any call for such in any other part of the Dominion? Is there any chance of such a project being established in other centres?

DR. STANBURY: There are several related projects as you will see at Page 85, Section 283. There is one that I presume you are referring to, the orthodontic clinic in connection with the cleft palate research unit. There is also under 285 an orthodontia for individual cases which has been quite successful and then 287, a dental survey and clinic for pre-school

children. These, as the name of the chapter implies, are projects that are developed by our Provincial Divisions, the Junior Red Cross within our Provincial Divisions under the principles laid down by our Central Council on the Division of our Junior Red Cross Advisory Committee of which Dr. Phair is the chairman. This would be a matter, I would say, for discussion with the Provincial Division and the Junior Red Cross concerned. I think, generally speaking, when we as a Society are able to demonstrate the usefulness of a project then other funds should be made available. In this case funds were subsequently obtained from the Atkinson Charitable Foundation to develop the project even further than was envisaged when the Junior Red Cross stepped into the picture.

COMMISSIONER STRACHAN: There is one statement here in the consolidated schedule designating reserve funds and under designated funds it mentions replacement of hospital equipment, Ontario. What would be involved in that?

MR. SHAW: Mr. Martin could answer that one --- perhaps I have a partial answer.

COMMISSIONER STRACHAN: The third to last item from the bottom.

MR. SHAW: These, I am quite sure, relate to specific requests and that sort of thing which come to the Society with a specially designated purpose attached. It is not unusual for the Society at the branch level, the request may come to a branch where it is specifically designated that the funds must be used for a special purpose, it is not at all unusual, as a matter

of fact, over the years many of the requests have been related to outpost hospitals and nursing stations and so on. Am I right about that?

MR. HULL: It is the Ontario Government. I do not know whether I can answer to your complete satisfaction, but it is Government funds from the Ontario Provincial Government which are given to Red Cross for the specific purpose of replacing certain equipment in the outpost hospitals; it is not funds from the public, it is a designated fund to that extent.

THE CHAIRMAN: Thank you very much, Mr. Shaw and gentlemen, it has been very nice having you here this morning. I would say again how grateful we are for the tremendous amount of work that went into the preparation of this brief which is, perhaps, in a way a history of the Red Cross in Canada. We may have been instrumental in getting you into motion to start and you finished with a very fine presentation this morning.

MR. SHAW: Thank you very much. Before we go, on behalf of our own group and a good many of our friends and supporters and many past officers of the Society who are in the seats behind us, I want to thank you and the Members of your Commission for the manner in which you have received us, for the understanding and the interest that you have shown and the understanding that you have displayed of what the Society has tried to do. We have to be so careful not to use the word "we" because it is too big for any of us. It has been a real pleasure to have this discussion with you, and we can only reiterate that we do hope that this submission will

prove useful to you; it cannot begin to be as useful to you as it is going to be to the Society as a whole. Thank you very much.

THE CHAIRMAN: We will take a few minutes recess now.

---Short Recess.

/dpw

THE SECRETARY: Mr. Chairman, the next submission is that of the College of Physicians and Surgeons. It will be known as Exhibit 298. Dr. Hannah will present the submission.

--- EXHIBIT NO. 298: Submission of the College of Physicians and Surgeons of Ontario.

SUBMISSION OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Appearances: Dr. J.H. Hannah
Dr. J.C.C. Dawson

THE CHAIRMAN: Dr. Hannah?

DR. HANNAH: Mr. Chairman and Commissioners, it is with a great deal of pleasure that we take advantage of the opportunity of being of service to the Commission in any way we can. Our submission is as a result of consideration by a Committee and as such, represents a composite opinion. We have tried to confine ourselves to those areas in which the College has a vital interest. With your permission, sir, I would like to introduce Dr. Dawson, the Registrar-Treasurer of the College. I am President of the College.

I presume that it will be in order for me to read the conclusions and recommendations.

CONCLUSIONS AND RECOMMENDATIONS

1) The College of Physicians and Surgeons of Ontario as established in 1866 has played and is continuing to play an important function in maintaining a high quality of medical care and ethics

among the profession and is protecting the public in Ontario against improper or inadequate medical care.

The College recommends that health matters remain under provincial jurisdiction and that the present functions of the College be continued and, that in co-operation with the provincial legislature, the problem of licensing to practise the healing art be studied as required with a view to assuring that those permitted to practise any part of health or medical care shall have at all times such basic training as will assure their ability to recognize their own limitations and that they possess adequate knowledge to deal competently with any emergency or threat to life which may arise out of any responsibility they may undertake.

2) Since the start of the increased immigration following World War II, a satisfactory doctor-patient ratio has depended upon admitting to practise in Ontario those immigrant doctors who have had suitable training. Diminishing numbers of graduates from countries with medical schools of equal standards to those of Ontario, and the increasing numbers seeking to register from schools of lower standards, is causing the College some concern in regard to maintaining high standards. If the quality of health and medical care in Ontario is to be maintained, it is essential that an immediate start be made toward securing and providing training for at least seventy-five (75) more medical graduates from Ontario medical colleges each year. Attracting an adequate supply of suitable applicants

for these requirements will require not only necessary facilities and financial assistance to all parties concerned, but will depend upon the prospects for satisfactory conditions under which practice may be carried on after graduation. The cause of the exodus of doctors from the United Kingdom should be carefully considered and repetition of such cause avoided in Canada.

The College recommends that the problem of providing and maintaining an adequate supply of medical students and doctors be carefully considered with the Association of Canadian Medical Colleges and the licensing bodies of all the provinces, and that financial support for these and research needs be a primary consideration and be recommended as a priority by this Royal Commission.

3) From 15 to 20 percent of doctors emigrate from Ontario immediatley following graduation. This loss fluctuates with economic conditions and prospects in Canada as compared with those in the U.S.A. Every effort, short of compulsion, should be made to keep our graduates in Canada. However, monetary inducements alone will not suffice to stem this flow. Freedom to exercise individual ability as well as assurance of a reasonable standard of living are essential. Any suggestion of outside control over practice will accelerate such an exodus.

The College therefore recommends that this Royal Commission give due consideration to all the various factors which have produced in Canada its full

share of top-ranking personalities in the health and medical care field so that we shall not exchange a progressive situation for one which has not been without an equal or greater number of more serious problems and, as in the United Kingdom, multiply costs without a corresponding increase in quality of service.

In order to encourage as many as possible university graduates to stay and become established in Canada, the College recommends that they be granted a period of at least five years free of income tax following graduation, after which they be charged an increasing ratio of normal income tax so that they shall reach the ratio normally applicable to their income by the end of the eighth year after graduation.

The College has a fairly extensive statistical analysis of its membership which give certain information regarding the distribution and classfication of doctors in relation to population and geography in Ontario. This did not become available in time for proper study. However, as soon as this has been done, and if it discloses pertinent information, the College is prepared to submit a supplementary brief.

It has been a pleasure for the College of Physicians and Surgeons on Ontario to contribute to the best of our ability to the studies of the Royal Commission on Health Services. It is hoped that if this College can be of further assistance, the Commission will accept that it will be a pleasure and a privilege to continue our co-operation.

THE CHAIRMAN: Thank you very much, Dr. Hannah. Just by way of explanation, on page 22, your paragraph 3) says 15 to 20% of doctors emigrate from Ontario immediately following graduation. Emigrate might connote going to another country, but do you include in this going to another province as well?

DR. HANNAH: No, it is to the United States only. I mean, there are others that do emigrate to various provinces, but we get exchange from other provinces. As a matter of fact, in the last few years, we have been on the beneficial end of that exchange.

COMMISSIONER FIRESTONE: I am just wondering whether that 15 to 20% includes also men who have graduated at the Canadian medical schools who are U.S. citizens returning to the United States.

DR. HANNAH: I think it does. It is a very small, relatively small, number.

COMMISSIONER VAN WART: On page 14, you state 15% to 20% of our graduates leave Ontario for the United States. Does that mean recent graduates only as in your summary statement or does that include all graduates of our medical schools?

DR. HANNAH: This figure is a very difficult one to determine. One sees statements about emigration of various people and various classes of people to the United States and there doesn't seem to be any too great consistency in the figures that are eventually published. You may recall there was such a study appeared in the Financial Post recently, but it did not break down the healing arts into their different

sections in which they belong. We have to say that roughly 15 to 20% of our graduates, at one time or another, leave Canada and settle in the United States and do not return to us. Included in that will be people who came to Canada from the United States to attend a college.

COMMISSIONER VAN WART: I was going to ask that question ultimately: about how many do you have from the United States attending your Ontario medical schools?

DR. HANNAH: I don't think we can answer that at the present time - 5%?

DR. DAWSON: The only figure I could give that would have any bearing would be the number of enabling certificates. We haven't got that figure available. It is a small number, roughly 3 to 5%.

COMMISSIONER VAN WART: Roughly 3 to 5%. Well now, of your students graduating, going over to take post-graduate work in the United States, have you any idea how many of them return to Canada to practise?

DR. DAWSON: This figure could probably be obtained for later submission, Mr. Chairman, but we haven't got it at the present time. It is quite a lot of digging.

COMMISSIONER VAN WART: Would it be 5%?

DR. DAWSON: That go over and return?

COMMISSIONER VAN WART: Of your graduates.

THE CHAIRMAN: That go over and remain was the question.

DR. HANNAH: The ratio that go over and remain would be much higher.

THE CHAIRMAN: I don't know what 5% is, 5% of those go over, 5% of total graduates or 5% of what?

COMMISSIONER VAN WART: The figure of 15 to 20% of the total number of graduates, that is what I am trying to break down.

DR. HANNAH: I think I might answer that question more intelligently this way: a number of those who go over for post-graduate work do return. It isn't as many as we would like, but to say exactly what it is we couldn't say at the moment.

We at the College have just this year put our statistics on I.B.M. equipment and that is the reason I indicated we have these tables, but it was only put on last year and we got these tables about three weeks after we finished our brief and we weren't able to study them satisfactorily and there are other factors we will have to get with them.

Even now, we may be able to give a better answer, a more specific answer to your question on percentage than we were when we made our brief.

DR. DAWSON: Mr. Chairman, the College does not keep a tracer on the graduates unless they register with the College upon passing their medical examinations and these graduates of Ontario medical schools who go outside the country for their post-graduate training or other purposes and subsequently return to Canada, we would have no way to tell from the ones that went to other provinces. We have no estimate of this

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figure at all. We have no tracer.

COMMISSIONER VAN WART: Have you any figures to show how many graduates who have been in practice, say five, six, seven or eight years in the Province emigrate to the United States?

DR. DAWSON: No.

COMMISSIONER VAN WART: I asked that question bearing on a suggestion made in Page 23, regarding the income tax. You make a suggestion that for five years they be exempt from income tax, and then the next three years gradually increase the amount of income tax so that they get to the normal level at eight years. Maybe this might not be an inducement for them to stay five years, and then pull out and defeat your purpose. I wondered if you had much of an emigration after five years at the present time?

DR. HANNAH: The best answer I can give you in regard to this is something I ran into as chairman of a committee that had to do with the compiling of a published register for the College of Physicians and Surgeons in Ontario, and this covers a period of all time, and does not give any suggestion as to when these people went to the United States, but there was something over 2,000 on our register who lived outside of Ontario, and there is still that number that retain the registration in Ontario, but live elsewhere. Now, whether they are practising there or not, I don't know.

THE CHAIRMAN: Dr. Hannah, the help that you can give us lies primarily, as you said, in your field as the governing body of the profession. I think we can start off with the proposition where you say that

you recommend that health matters remain under Provincial jurisdiction. I suppose that is about the easiest wish you might ask for, and that you know that you will be granted, because I imagine that it would take a revolution to change that, but in this question of licensure, the College of Physicians and Surgeons is the agency of Government for that purpose?

DR. HANNAH: Yes, sir.

THE CHAIRMAN: And as I understand it, in Ontario you concern yourself with that as one of your primary functions, the qualification and the admission of doctors to practice?

DR. HANNAH: Yes, sir.

THE CHAIRMAN: And then I suppose the next one is the quality of medicine in Ontario, insofar as the conduct of the profession is concerned?

DR. HANNAH: Yes, sir.

THE CHAIRMAN: And I want to take you into a field that you may think is controversial, but I think it is one of those fields, it is one of those topics that must be discussed openly at this time, and that is the status, the future of the groups such as chiropractors, and others, the podiatrists, the optometrists, and when you go into dentistry, the denturists, and in nursing we hear of a secondary category. This whole group, now, so far as the College of Physicians and Surgeons is concerned, basically are these people regarded as being members of the healing art?

DR. HANNAH: Basically we regard them as being practising in the field of the healing art. As

you say, this is a live question, open to controversy, and I think ----

THE CHAIRMAN: To controversy and discussion.

DR. HANNAH: And discussion.

THE CHAIRMAN: Yes.

DR. HANNAH: I think I tried to deal with that in the body of the brief, Mr. Chairman.

THE CHAIRMAN: Yes, I know. It is because you have dealt with it that I am opening the question now in this way.

DR. HANNAH: Over the years there has developed various cults within the healing art, and when the College was established there were special cults within the profession itself, for which provision was made for representation on the Council of the College. The homeopaths.

THE CHAIRMAN: Well now, the osteopaths is another one that I didn't mention.

DR. HANNAH: At the present time we have been carrying on discussions through committees with the osteopaths, and it is my concept, rightly or wrongly, and from what I can gather of the history of the development of the College of Physicians and Surgeons, it was established in the hopes that it might constitute in the early days the arm of Government through which the standards for the entry into practice in the healing art might be obtained.

THE CHAIRMAN: Do you mean now entry into, not only the medical profession, but others?

DR. HANNAH: Well, I think it was the hope that it would relieve the Government of the necessity of having to deal with these bodies piece-meal in the form of special legislation for each particular group. This, however, is not the circumstances which have developed over the years. Unfortunately, somehow or other the College of Physicians and Surgeons, and I think we must remember that at that time there were not the well-organized, or well-coordinated groups that we have at the present time, and perhaps in the minds of the legislature at that time they thought that the only thing they had to be concerned with was the medical profession.

More recently we have been faced with the problem of how can we maintain a high standard of quality in everybody who goes into the field of practising the healing art. Of course, as occurs in every piece of restrictive legislation, those who are restricted object, and of course, they get their following.

If you go back in the history of osteopathy for instance, I recall even in my short lifetime the total antipathy that there was between the medical profession and the osteopaths. Now, I am not suggesting that it has all gone, but in recent years there has been an application on the part of the osteopaths to become part of the regularly registered profession in the United States, and we are faced with that in Ontario at the present time, and we are studying the problem.

Now, out of this request in the United States, one osteopathic school in California has now been accepted as a medical college, and its graduates are given

enabling certificates to write the same examinations as the graduates of other medical schools in California.

The other osteopathic schools in the United States, for one reason or another, either because the profession inspecting the college didn't feel they measured up to standard, or because they themselves didn't wish to become part of the medical profession as a whole, have remained out of the general registration of physicians.

Now, we in Ontario are giving consideration to the establishment of a system, or at least of collaborating with the profession across the line, in studying the osteopathic schools, to see whether or not they have reached a level in their basic science training and their clinical training which we feel will permit them to be admitted and registered, at least with restricted licence, and this has been discussed between the osteopaths and ourselves in the committee, but throughout the years osteopaths have gradually added to their training, their basic sciences, their anatomy, their physiology, and all the other factors.

I think at the present time they make the statement that if medical doctors could be permitted to teach on their staff, they would be able to turn out graduates of equal quality with the medical schools. Now, I don't think that is the concept of all the osteopathic schools by any means, but is shows you the trend of things.

Now, if we are discussing things frankly ----

THE CHAIRMAN: Yes.

DR. HANNAH: We must also give consideration to the chiropractors. We in the profession have no brief for any particular form of treatment, so long as it conforms with high standards.

Recently the College was asked, in response to a request or a suggestion by the Chairman of a Coroner's Committee, the suggestion was made that chiropractors should be trained sufficiently that they would be able to recognize the dangers inherent in certain situations.

THE CHAIRMAN: I suppose that situation was following an accident?

DR. HANNAH: Yes. Following that suggestion, we received a communication from the chiropractors' school here in Toronto that we should permit doctors to teach on their staff. We in turn wrote and asked them for their curriculum, the curriculum of their basic sciences, and what facilities they had for teaching these subjects. To date we have not had an answer from them. We had an answer, I am sorry, but the answer implied that they were re-organizing their curriculum, and as soon as it was ready we would have it.

DR. DAWSON: I believe the inquiry went to the Chiropractic College in January or February, and the reply came back.

DR. HANNAH: Now we feel, Mr. Chairman, that if such requirements are necessary, as is suggested in that recommendation, that the facilities are already in existence where these things and these studies may

be carried on by anybody who wishes to go into the field of the healing art, there are medical schools, there are scientific schools in connection with the others, that teach these basic sciences; medical training is not necessarily all received in medical schools. I myself, for instance, took my chemistry in an arts faculty, and my physics the same way, and in the college where we were doing anatomy we had art students who were studying these subjects, and certainly my biology was taken with art students and in the arts school.

So that these facilities are available and it could be set up as a special thing in each of these schools and they are being provided through our educational system, and we think that if an individual wants to practise a particular type of healing art, that having gotten these basic things, then he will be in a position that he will be able to be of much more satisfaction both to himself and to his patient and perhaps, indeed, be able to carry on the healing art more satisfactorily.

THE CHAIRMAN: And in such an atmosphere, who would be the licensing agent? Would you suggest this would be the College of Physicians and Surgeons, they would go back to that original concept which you had of being the one body to license and regulate?

DR. HANNAH: This would be the ideal position. I think that with vested interest in art at the present time that may not be the answer at the moment. But I do feel, however, that there is a necessity for a similar requirement, a standard equivalent to, if you like, the standard that the medical profession has to meet and that they voluntarily impose on themselves or through such bodies as the College of Physicians and Surgeons

THE CHAIRMAN: You see, the position to us as laymen, we have the chiropractors, we have the optometrists, and so forth. They appear to have a considerable following in the general public and they are making requests that in any health services program provision be made for their recognition so that they may continue to carry on

that part of the healing art that they say they are capable of doing, and it is a very practical problem to this Commission as to just how and by what manner this is to be accomplished, if it is to be accomplished, if it is in the public interest it should be accomplished, and that is why I put the question to you, because we, as I say, appreciate your forthright views very much. As a spokesman for the College of Physicians and Surgeons, we look to you for help here.

DR. DAWSON: Following your remarks, Mr. Chairman, there are one or two points I would like to express.

First of all the College is charged, as you are aware, with the administration of the Medical Act, and only those can practise medicine, midwifery, who are qualified under the section of the Act, and chiropractors do not in any sense ---

THE CHAIRMAN: At this moment, your regulations, the regulations of the College of Physicians and Surgeons, are they subject to approval by the Lieutenant-Governor in Council?

DR. DAWSON: Only one regulation is subject to approval by the Lieutenant-Governor in Council, and it is not pertinent to us here. This authority is given to the College of Physicians and Surgeons under the Medical Act.

THE CHAIRMAN: In the one province I am most familiar with the regulations are subject to approval of the Lieutenant-Governor in Council, not only of the medical profession but of the legal profession

[illegible]

and the others.

DR. DAWSON: The question of the practice carried on by chiropractors, chiropractors by their training in their four-year course are trained to deal in the field of manipulation, and I believe it is their concept that disease stems from pressures on the vertebrae, the bony structure of the spine, and that, I believe, is their concept. But chiropractors are not restricting themselves to this method of treatment, nor are they capable of investigating illness. Chiropractors are engaged in the practice of medicine poorly trained, without adequate instruction in the basic sciences, without the facilities or the staff to carry this out. Now, if chiropractors would stick to what they are licensed to do there would be no conflict with the medical profession, I feel.

Now, this opinion you would have to get from those in the clinical fields, because I am not now practising in that capacity.

THE CHAIRMAN: This we are prepared to accept as being the view of the College of Physicians and Surgeons. I suppose the chiropractors will say: "No, we are not doing that, we are acting wholly within the law." Can you suggest any form or organization by which this seeming conflict might be resolved, in the public interest?

DR. DAWSON: It was dealt with on the question of overall legislation with one body providing the licensing. He didn't mention until recently there was a small number of homeopaths in Ontario who were licensed under the Medical Act by the College of Physicians

and Surgeons. They had a representative on the council of the College, and this was established by the Medical Act.

Now, this could be handled in the same manner by certain other groups who are practising in the healing arts. I believe that matter has received some study, but it hasn't got very far.

DR. HANNAH: The first requirements, Mr. Chairman, for such a possibility in my opinion would be that any chiropractor, osteopath, any other, would require certain standards of basic sciences, and these would be established, the same ---

THE CHAIRMAN: Who is going to fix these standards? That is the question. Each profession, actual or so-called, governs itself. For a health service of the future, is that going to be good enough or must we see some other structure that will see that every branch of the healing art is properly qualified?

DR. HANNAH: We already do that, sir, in our standards for entrance to university. We must have what we call matriculation. Now, there may be variations in the form of matriculation one takes, but there is a standard and an equation of the standards in various provinces which exists at the present time. That is one of our big jobs in the College of Physicians and Surgeons; we must equate a Grade XII in Saskatchewan with a Grade XIII in Ontario, and the same in Quebec.

Now, it would seem to me that if we have reached that standard, that standard equation, entering into a higher educational field, it shouldn't

[illegible]

be difficult to reach a similar standard. But I think we should be aware of the fact that just as soon as we do establish these things we are going to run into a repetition of things that occurred in the past.

THE CHAIRMAN: Somebody with something new?

DR. HANNAH: Yes, somebody wants to practise with less qualifications; he will go to a Member of Parliament and he will have a following, and unless we are strict enough and strong enough we will have acquiescence. I think in Ontario there were 22 pieces of legislation for those working in the healing arts and professions.

So it seems to me that even though the matter of health is of great importance to everybody concerned, we are not prepared to accept the close standards that we apply to the matter of our entry into other forms of higher education. This, I think, is what is needed.

THE CHAIRMAN: Thank you very much, Dr. Hannah.

COMMISSIONER FIRESTONE: Dr. Hannah, I would like to refer to the second paragraph on page 23, the subject of your recommendation of encouraging as many as possible graduates entering the practice of medicine,"they be granted a period of at least five years free of income tax following graudation, after which they be charged an increasing ratio of normal income tax so that they will reach the ratio normally applicable to their income by the end of the eighth year

after graduation." I am just wondering whether you may not feel as encouraging such a move might be, whether this would not represent a certain amount of discrimination in favour of one professional group as against other professional groups and that the introduction of such a provision would create a precedent that governments may have to face in the light of demands coming from other groups for a similar concession?

DR. HANNAH: Mr. Chairman, may I point out, Professor Firestone, that I have not confined, at least the College has not confined the recommendation to medical graduates. The term is "university graduates" as a whole. So there would be no precedent because it applies across the board in that respect, if that is the suggestion. This suggestion and recommendation arose out of the fact that we are losing from 15% to 20% of our graduates across the line. Now, it costs somewhere in the neighbourhood, when you figure time and everything else -- and it doesn't matter who pays it, whether I pay it as an individual or a government pays it -- it is costing Canada so much to educate me as a doctor. Now, my time, if it is not employed constructively in becoming a doctor or in the practice of medicine, would be employed constructively elsewhere, and so therefore in figuring the cost of education we must consider the time, and so on. When it is realized that it costs somewhere in the neighbourhood of $25,000.00 to $30,000.00 to educate and put a doctor in the field of practice, maybe, or the same may apply to other fields of university graduates, the loss of these people

alma mater." I am that wonderful mother who may not feel as proud as she should, but, whatever this would not represent a concrete concept of education in terms of our traditional ideas as against some professional course. [illegible] the introduction of such a provision would come to a precedent that professional work may be in face in the light of common core [illegible] other courses [illegible] similar concepts?

Mr. [illegible]: Mr. Chairman, may I point out, Professor [illegible], that I have not combined, at least the College has not combined the recommendation to [illegible] [illegible]. The term is "university grade" as a whole. So there would be no precedent because it covers across the board. That respect, if that is the suggestion. This suggestion and recommendation [illegible] out of the fact that we are looking upon the [illegible] of our graduates across the line. Now, it costs [illegible] in the [illegible] thousand, when you [illegible] and everything else -- and it doesn't matter who pays it, whether I pay it as an individual or a government pays it -- it is costing [illegible] so much to educate me as a doctor. Now, I think, if it is not [illegible] considered [illegible] in accounting a doctor, or in the practice of medicine, [illegible] [illegible] consultants, [illegible], and so forth, the cost of education [illegible] the time, and so on. [illegible] [illegible] that is [illegible] [illegible] the [illegible] of [illegible], [illegible] to [illegible] [illegible] a [illegible] [illegible] of [illegible], [illegible], or [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] the loss of [illegible] [illegible]

to a place where we are not going to reap the benefit of their education and imagination and ability is a matter of great extent and may even result in the long run, with the provision of jobs here, that the loss of income tax may not be a loss at all. It would depend a little bit on the concepts, but it was our hope in making this recommendation that we might stir up some thought as to the loss that is occurring not only in the medical field but in the whole field of university graduates not staying in Canada.

COMMISSIONER FIRESTONE: Thank you for answering that you have in mind all university graduates. But if I may confine my question to medical graduates for the moment, I am just wondering whether this recommendation might not be achieved in some other way. For example, one could have a system which would permit an accelerated depreciation on equipment and other capital expenditures associated with the opening of a medical practice, which would then mean giving the medical practitioner the possibility of charging largers expenses against his income and reducing his income tax liability for two years. Another possibility would be a deferment of income tax, either in whole or in part, to a later period so the doctor would be left with a greater net income but he would have the opportunity of paying these income taxes at a later date when his gross income is much larger.

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I am raising these questions because either of these alternative methods would really not mean a loss of tax revenue to the state but it will mean a deferment of income tax and help the medical practitioner at the time when that help is most needed.

DR. HANNAH: I think in such a consideration one must remember that it is not necessarily a question of the immediate economic prospect that is involved although both suggestions, the recommendation that we have made and the one you have suggested, would appear to be temporary arrangements. Both might permit the individual some compensation for his extra long time that he has to put in, particularly if he goes into a specialty. However, there is an additional factor of the long term economic inducement, not only that but, as I have said so frequently, I do not like discussing the economics of medical care as a separate entity because I do not believe it can be separated from the other factors. There are very few prospects of ever becoming really wealthy within the practice of medicine; one might have a comfortable living, that is, in the sense of social standing but a great many of them do not have a comfortable living in the sense of being able to stay in bed all night, et cetera. The conditions under which people entering the medical profession get their satisfactions are a little different from those which actuate people into other professions. There are others who may get the same incentive but the peculiar rewards of the medical profession are more apparent and more real to the individual who enters medicine for the sake of medicine. He does not go in

with the concept that he is going to get rich but he goes in because he has a peculiar liking for the type of reward that he gets. You find the same in the nursing profession, et cetera. The two types of people are not always suited for each other's type of vocation so one must give due consideration to the long term satisfactions, not only economically but to the whole picture.

COMMISSIONER FIRESTONE: Those are very thoughtful comments that you have made. Thank you very much.

COMMISSIONER VAN WART: Just one other point; on page 22 in the first paragraph you state:

"The cause of the exodus of doctors "from the United Kingdom should be "carefully considered and repetition "of such cause avoided in Canada."

On page 17 you elaborate quite extensively on the national health services in the United Kingdom and you give that as a cause for the shortage of doctors practising in the United Kingdom. No consideration has been given to the curtailment of the quota of students entering the medical school shortly after the war which is considered fundamentally the cause of the shortage of doctors in the United Kingdom at the present time. There is no mention of that factor, you just leave it with the idea it is up to the National Health Services plan entirely.

DR. HANNAH: Well, Mr. Chairman, I agree that the restriction of entering into the medical

[illegible]

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[illegible]

schools following the war could well have had something to do with the present day shortage of doctors in Great Britain. However, it does not account for the exodus of 220 doctors each year during the past ten to twelve years to Canada alone. The suggestion as contained in certain reports both -- I should not say "reports" in the sense of it being a study but in discussions of the matter of both lay and medical men in Great Britain it would seem to indicate, and in disucssion with those who come to Canada, the certain limitations on the satisfactions of life under the National Health plan has been a very prominent factor in those doctors to leave and come to Canada. I discussed this matter with physicians at other places and this has been along with certain benefits that have accrued from the National Health plan have been cited as a very bad situation in contributing very seriously to young men of promise who forego entering into the medical profession as compared with some other fields.

COMMISSIONER VAN WART: Would you expect then the fall-off in the number of doctors coming from the United Kingdom at the present time it would happen, under the explanation you have given, the exodus should continue.

DR. HANNAH: It could but insofar as we in Ontario are concerned I believe the important immediate factor as far as we are concerned in relation to this report will be found in the table that we put on page 11. On that table it shows the number of doctors who become licensed with their country of origin

and from 1945 up until 1961 and the table generally follows a fairly consistent pattern of the diminution of the ratio of doctors of Canadian origin registering in Ontario as compared with the country of origin, the doctors registering from other countries of origin. It is interesting to follow those through and note, without going through the whole thing, but in the first column the Canadian graduates dropped from 98.2% in 1945 to 72% in 1961 and went as low as 52.1% in 1958.

In the next column we see the registration from the Anglo-Saxon countries, England, the United States, Australia, et cetera. And now, over a period of time it increased from 1.4% in 1945 until in 1961 it was 11.9% and reached a peak of 27.8% in 1958 so that there was a gradual increase. However, there is a gradual falling off. Whether or not this falling off will be continued is hard to say but if it does continue it gives rise to a serious problem in Canada because if you go over to the third column it represents the graduate from the universities in the United States, we can leave that out for all practical purposes because it is only 7% of the total but if you go over to the fourth column we find that the numbers registering from other countries, non-Anglo-Saxon countries, rose from .4% in 1945 to 13.6% in 1961. This is all to the good for those people who have the quality of training that meets our requirements and our standards but unfortunately there are a large number of schools where we run into difficulty with the graduates from those schools because they have not got the basic training that warrants our

consideration for registration in Ontario but, indeed, in Canada, in my opinion.

COMMISSIONER VAN WART: What year did you have the Hungarian influx?

DR. HANNAH: 1956-57-58, I think in that period.

DR. DAWSON: That was reflected in the next two years by the time they met their intern requirements.

COMMISSIONER VAN WART: This probably would show in the figures 1958-59.

DR.HANNAH: There appears to be a diminution in the number of people we can expect to make entry in the near future with the result if we are to maintain the physician-population ratic that is necessary for the higher quality of medical care we in Ontario must graduate, in our opinion, something in the neighbourhood of 70 to 75 doctors a year more than we are doing at the present time. This is for Ontario, not for Canada as a whole but Ontario as a whole and the rest of Canada will have to do similar things if they are to maintain that ratio. I know there is this interchange of graduates, we send some out west and some of the western ones come here but this is a problem we are faced with here. I think this is going to become an acute problem and how to solve this is quite a serious problem and that is the reason for our recommendation that this matter be taken up with the deans of the various medical schools in Canada and the licensing body of the provincial governments with a view to seeing

whether or not something cannot be done. With all of the talk there has been about government subsidization of things we realize there must be government subsidies for our education institutions but I would hope that they be recognized as an investment for the country as a whole in the matter of education and we will get a return on it.

THE CHAIRMAN: Thank you very much, Dr. Hannah. I am very grateful to you for this discussion and for your frankness in presenting your view.

DR. HANNA: Thank you very much, it has been a pleasure.

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whether or not something cannot be done. Well all of me tell them, we know about government administration of things we realize there must be government at some for our education institutions but I would hope that they be recognized as an investment for the country, as a whole in the matter of education and we will get a return on it.

MR. O'NEAL: Thank you very much.

Mr. Chairman, I am very grateful to you for this discussion and for your frankness in presenting your view.

DR. HAMMA: Thank you very much, it has been a pleasure.

THE SECRETARY: The next submission is that of the Canadian Cardiovascular Society known as Exhibit 299. Dr. Kelly will introduce his group.

S U B M I S S I O N O F

THE CANADIAN CARDIOVASCULAR SOCIETY

---EXHIBIT NO. 299: Submission of the Canadian Cardiovascular Society.

APPEARANCES:

DR. D. WILSON
DR. H.G. KELLY
DR. R.W. GUNTON
DR. J. KEITH

DR. KELLY: Would I be in order to introduce my colleagues: Dr. John Keith, Dr. R. Gunton and Dr. Donald Wilson. I should like to express regrets of the President of the Society Dr. W. Ford Connell who was unable to be here today because of illness.

Sir, the Canadian Cardiovascular Society which used to be known as the Canadian Heart Association is a voluntary organization and has a membership of about 300 doctors, practitioners, medical specialists, surgeons, teachers, researchers, doctors who have a common interest in the prevention and treatment of heart disease, which as the Commission knows, kills more Canadians than all other diseases combined.

It has prepared a short brief which in some respects duplicates the more extensive brief which

THE SECRETARY: The next application is that of the Canadian Gamblingmen's Institute (Exhibit 24). Mr. [illegible] will introduce the group.

---XAMINATION OF [illegible] Commission of the Canadian

[illegible]

Rev. D. M. [illegible]
Mr. L. [illegible]
Mr. [illegible]
[illegible]

Mr. Chairman, Honourable [illegible] gentlemen: Dr. John [illegible], Mr. [illegible] and Mr. Donald [illegible]. I should like to express regrets of the President of the Society Dr. W. [illegible] Commissioner was unable to be here today because of illness.

Sir, the Canadian Gamblingmen's Institute Society which seeks to be a church in the [illegible] Association is a voluntary organization made up of people of about all bottoms, protestants, [illegible] Catholics, Christians, Communists, agnostics who have a common interest in the prevention and treatment of [illegible] disease, which as the Commission knows, kills more Canadians than all other diseases combined.

It has produced a short brief which is some [illegible] duplicate the more extensive [illegible]

the Commissioners heard from the Canadian Heart Foundation. It makes some points which will be made in more detail later by the brief of the Canadian Society for Clinical Investigation.

It is recommending and it feels as a result of the diversity of interests and its membership that it is well versed to speak on these matters, it is recommending expanded support by Government for medical research in heart disease. It is recommending the inauguration of a support program for clinical training in cardiology as opposed to research training, for the inauguration of support programs for career investigators in cardiology and for inauguration and support for specialized cardiovascular units in major teaching hospitals.

These the Society feels are the important areas where there exists a deficiency with respect to the contribution of Government towards advancement in the field of heart disease. These comments are in the summary at the back page. There are these areas we support, and figures of cost programs, cost being inserted, which I should point out represents the total cost. They are not meant to be figures that indicate Government should pay for all of this. These are figures which estimate what the country can absorb, how much money the medical schools, teaching hospitals, research institutes can absorb and use wisely and efficiently in this time, within the next few years. In every instance it naturally represents an increase over what money is available at the present time, both from Government and from private organizations that are raising funds from the

the [illegible] heard from the Canadian Heart Foundation[illegible] it made some points which will be made in more detail later by the brief of the Canadian Society for Clinical Investigation.

It is recommended, and I think as a result of the diversity of interests and [illegible] that it is well for me to speak on these matters, it is recommending a continued support by Government for medical research in heart disease. It is recommending the inauguration of a support program for clinical training in cardiology as opposed to research training, for the inauguration of support program for career investigators in cardiology and for inauguration and support for specialized cardiovascular units in major teaching hospitals.

These the Society feels are the important areas where there exists a deficiency with respect to the contribution of Government towards advancement in the field of heart disease. These comments are in the summary at the back [illegible]. These are three areas we support, and [illegible] of [illegible] programs, [illegible] increases, which I should point out represents the total cost. These are the [illegible] to the [illegible] that in fact [illegible] for [illegible]. These are figures [illegible] the [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible]

public. These figures do not represent any increase over money being presently spent and the Society is not suggesting the Government should be paying for all this. With those points I think we would now be prepared to answer any questions which you might care to put to us.

THE CHAIRMAN: Thank you very much for that explanation. It opens up the subject very nicely. Dr.Firestone.

COMMISSIONER FIRESTONE: If I may follow up with these figures you were good enough to present as a desirable program of medical education, medical research and research laboratories in your specialized field. You are suggesting annual requirements in the initial period of $5.8 million. Sir, what are the comparable figures of expenditures now being made in these three areas in Canada?

DR. KELLY: This would be around $4,000,000.00 or slightly less from all agencies of Government and from private sources, particularly the Heart Foundation, sir.

COMMISSIONER FIRESTONE: This $4,000,000.00, could you tell us what amount the Federal Government contributes to that amount of $4,000,000.00, or close to $4,000,000.00?

DR. KELLY: The Heart Foundation are contributing approximately $1,000,000.00 toward medical research at the present time and almost all of the balance is coming from Government, from the various agencies, from the Research Council principally, the National Health and Welfare to a considerable extent,

and then the Defence Research Board to a considerably smaller extent.

COMMISSIONER FIRESTONE: If I understand you correctly, sir, we face at the present time a total budget close to $4,000,000.00; $3,000,000.00 from the Federal Government and $1,000,000.00 from other sources. These figures are approximate?

DR. KELLY: Yes.

COMMISSIONER FIRESTONE: To visualize your program of $5.8 million would you expect the Federal Government contribution be raised proportionately to the present division between the Federal Government and other sources, because if you do the figures would work out roughly to $4.5 million from the Federal Government and $1.3 million from other sources.

DR. KELLY: Well, Dr. Firestone, what seems to be happening in the last couple of years is that the amount of money that is being requested for medical research is increasing at quite a sharp rate, a slope, a rate of climb faster, really, than the voluntary agencies are able to raise it, so that there is a feeling in the Society that Government should perhaps --- the contribution from Government should increase proportionately more, at least, for a period of time until supply catches up with demand. Dr. Wilson could speak with regard to the experience of the Ontario Heart Foundation in the last couple of years on this matter.

DR. WILSON: I would just reinforce what Dr. Kelly said. The Medical Committee of the Ontario Heart Foundation, their demands or requests for funds

[illegible] to a [illegible]

[illegible]

[illegible]: If I [illegible] stand [illegible], sir, we have at the present time a [illegible] [illegible] $4,[illegible]; $5,000,000.00 from the Federal Government and $1,[illegible],000.00 from other

[illegible]

[illegible]: In [illegible] work program of $1.8 million would enable the Federal Government contribution be matched proportionately to the present division between the Federal Government and other sources, because if you do the figures would work out roughly to $4.5 million from the Federal Government and $1.3 million from other sources.

M. KELLY: Well, Dr. Fisherton, what seems to be happening in the last couple of years is that the amount of money that is being requested for medical research is increasing at quite a sharp rate, a [illegible], a rate of [illegible] faster, really, than the voluntary agencies are able to raise it, so that there is a feeling in the [illegible] that Government should perhaps --- the contribution from Government should increase proportionately more, or, least, for a period of time until supply catches up with demand. [illegible] agree with a request [illegible] the extension of the [illegible] [illegible] on the last [illegible] [illegible] on this matter.

Dr. [illegible]: I would just [illegible] that Mr. Kelly said. The Federal contribution to the medical research [illegible], really depends on resources [illegible]

have increased over $200,000.00 over the past year as opposed to $150,000.00 for the year before, so that the demands are increasing each year and our budget demands over the past six or seven years have gone from $100,000.00 to $920,000.00 in the Province of Ontario.

COMMISSIONER FIRESTONE: If I understand you correctly, gentlemen, your suggestion would be this $5.8 million which is the Canadian national total would be made up, perhaps, again to the extent of $1,000,000.00 or so from other sources and about $4.8 million from the Federal Government to take account of the principles which you have enunciated, that the Federal Government contribute for a period a growing ratio. Am I correct in that understanding?

DR. KELLY: That is right.

COMMISSIONER FIRESTONE: Let us assume such increased grants are made available. Are there sufficient research personnel available to use the $5.8 million efficiently and produce the sort of research of quality and type which you consider is required in the program?

DR. KELLY: Yes, sir. It is the view of the Society that this sum could be spent wisely and efficiently, not necessarily next year, but within the next three or four years with no waste. For instance, it is my understanding that the Medical Research Council this year, despite a substantially increased budget still had to turn down about --- I have the exact figure in here. The applications exceeded available funds by 80%, and the majority of these applications I am informed were sent in

by qualified investigators who could be relied upon to use the funds wisely and effectively.

COMMISSIONER FIRESTONE: I am just wondering, just taking the point you made, Dr. Kelly, whether you would envisage the program developing in stages, perhaps, starting by raising the total amount available from $4,000,000.00 to $5,000,000.00 in the first year and then more the second and third and fourth and fifth year, and perhaps by the fifth year you might reach $7,000,000.00, and the average would be $5.8 million or $6,000,000.00 over the five-year period. Is that what you have in mind rather than a single figure equal for every year?

DR. KELLY: That is right, sir.

COMMISSIONER FIRESTONE: That is very helpful. I have one more question, sir. You suggest on Page 8 in the top paragraph there is a need, not only for more money, but also and I quote: "Greater flexibility in their administration", and you refer here to the administration of Federal Government grants, I take it. Could you elaborate what you mean by greater flexibility of administration?

DR. KELLY: Well, sir, there are all grades of investigators. There are the young fellows who are starting off who have research grants awarded on a year to year basis. These gentlemen must be held to a strict accounting for their expenditure of their funds. The more mature and the more senior investigators who are developing research laboratories and are training young men, fellows like Dr. Keith and Dr. Gunton, they have

funds coming year after year and there is much to be said for allowing senior men of proven stature a certain amount of autonomy in the distribution of their funds within the total amount that has been allotted. That is basically what that meant. It simplifies the operation of large research units to have that privilege rather than have to write someone for permission to spend $100.00 or to change the type of apparatus they want to buy or to do something that was not foreseen at the time they made application. Perhaps Dr. Keith and Dr. Gunton might add something.

DR. KEITH: I would like to say you make your application in, say, September or October of 1961 for use in 1962 - 1963. By the time your grant is approved and you start to work on it, you have changed some of the facets of what you are going to do, inevitably, as your work proceeds. If you have, say, $10,000.00 to spend on specifically what is listed, unless you can change the categories within that $10,000.00 that really puts a strait-jacket on all your work and makes it difficult to carry out research work adequately.

COMMISSIONER FIRESTONE: Have you found in practice there exists such a strait-jacket?

DR. KEITH: Yes, so much so that granting bodies count on saving 10% of what they grant. They know right away they will save 10% of the grant, because people cannot spend it.

COMMISSIONER FIRESTONE: They cannot spend it for the purpose listed in the application.

DR. KEITH: That is right.

[illegible] course [illegible] year [illegible] have [illegible]
[illegible] to [illegible] security [illegible] [illegible] person [illegible]
[illegible] or autonomy in the [illegible] portion of their [illegible]
within the [illegible] about that [illegible] [illegible]
basically what that means. It [illegible] the [illegible]
of [illegible] [illegible] have that [illegible]
[illegible] to write [illegible] for [illegible]
or to change the type of [illegible] they want to buy or
to [illegible] that was not [illegible] at the time they [illegible]
[illegible]. Perhaps [illegible] Mr. [illegible] and Mr. [illegible] might add

M. [illegible]: I would like to say you
make your application in, say, September or October of
[illegible] for use in 1 [illegible] - [illegible]. If the [illegible] grant is
approved and you start to work on it, you have changed
some of the [illegible] of what you are going to do, [illegible]
as your work proceeds. If you have, say, [illegible] to
spend on specifications which is listed, unless you can
change the [illegible] within that [illegible], that really
puts a stumbling block on the work you have to
[illegible] to carry out research work [illegible].

[illegible]: Have you [illegible]
in great [illegible] [illegible] such a [illegible]

M. [illegible]: [illegible] so much
[illegible] on [illegible] or more than [illegible].
They know [illegible] than [illegible] [illegible]
[illegible] [illegible] [illegible] it.

[illegible]

[illegible] in the [illegible] [illegible] in [illegible].

[illegible]: [illegible] [illegible].

COMMISSIONER FIRESTONE: But they could spent it...

DR. KEITH: On other things.

COMMISSIONER FIRESTONE: On related types of expenditures, is that what you mean, sir?

DR. KEITH: That is right.

DR. GUNTON: Another way in which greater flexibility could work to advantage would be in the grants having a duration greater than one year.

[illegible]

MR. WHELDTCROW: I'm sorry. Why don't you [illegible] spend it...

MR. KELTI: In other things.

[illegible] times of [illegible] wars, is that what you mean, sir?

[illegible]

[illegible] flexibility could work to advantage would be in the event having a mutation greater than one year.

dpw

Certainly in a number of research projects the personnel to be employed in the grant must be employed at least a year in advance. If, for some reason, the grants were to be discontinued there would be uncertainty of employment of those personnel.

It has been suggested that in some cases grants should be made for longer periods of time and I believe this is now being actually entertained by the Department of National Health and Welfare, and I think this would be an advantage, and in the area of greater flexibility.

COMMISSIONER FIRESTONE: We have heard before that you really want to promote a plan of research for several years, instead of one, and I think that makes a good deal of common sense, but to come back to this question of strait-jacket terms of making grants available; has your group made representations to the Department of National Health and Welfare on this point, and if so, what answers did you receive?

DR. KEITH: We brought it up, I suppose, regularly for 10 years or more, and they say this is the way it must be done.

COMMISSIONER FIRESTONE: What are the reasons why it must be done that way?

DR. KEITH: I don't know if they have set them out in great detail. It is just that they feel that it is necessary in order to ensure that the Canadian money that is being granted be spent with the greatest care and supervision, that this is the safest way for them to do it.

certainly in a number of respects.

Objects the personnel to be employed in the grant must be employed at least a year in advance. If, for some reason, the grants were to be discontinued there would be uncertainty of employment of these personnel.

It has been suggested that in some cases grants should be made for longer periods of time and I believe this is now being actually contemplated by the Department of National Health and Welfare, and I think this would be an advantage, and in the area of greater flexibility.

[illegible]

before that you really want to promote a plan of research for several years, instead of year, and I think that makes a good deal of common sense, but to come back to this question of [illegible] short-ranged terms of making grants available; has your group made representations to the Department of National Health and Welfare on this point, and if so, what answers did you receive?

Dr. KUHLEN: We brought it up, I suppose, regularly for 11 years or more, and they say this is the way it must be done.

CHAIRMAN [illegible]: Just are the reasons why it must be done that way?

Dr. KUHLEN: I don't know if they have ever been set in great detail. It is just that they feel that it is necessary in order to ensure that the [illegible] money that is being granted is spent with the greatest care and supervision, that this is the [illegible] way for them to do it.

Not only do they do this, but they have a chartered accountant come to the hospital from Ottawa at intervals and check that a certain piece of equipment has been bought, and it is on the books and they go and look at the piece of equipment. I think this is a good practice and I am not decrying it at all, but it shows you how careful they are that all the money is spent exactly as listed in the application.

COMMISSIONER FIRESTONE: There is no objection to auditing. I think your objection is to what you call the strait-jacket approach with no allowance for discussion by the researchers. If discussion were allowed with the researchers, you would have no objection to the careful checking that is taking place, I take it?

DR. KEITH: No, none whatever. I suppose that they feel that being in Ottawa at some distance away, it is harder to keep control. In Ontario, in the Ontario Heart Foundation, which is closer to the research worker, it allows more flexibility in the grant money.

COMMISSIONER BALTZAN: I hope you will be able to bring me up to date on some of these things. You and I probably realize that I should know what I am going to ask you, but I don't. Is the Canadian Heart Society associated now with the Canadian Cardiovascular Society, does it grant any scholarships at the present time?

DR. KEITH: No, it is not a granting body, the Canadian Cardiovascular Society.

[illegible] only do they do this, but they have a chartered accountant come to the capital from Ottawa at intervals and check that a certain piece of equipment has been bought, and it is on the books and they go and look at the piece of equipment. I think this is a good practice and I am not decrying it at all, but it shows you how careful they are that all the money is spent exactly as listed in the application.

COMMISSIONER FERGUSON: There is no objection to auditing. I think your objection is to what you call the [illegible] -basket approach with no allowance for discussion by the researchers. If discussion were allowed with the researchers, you would have no objection to the careful checking that is taking place, I take it?

DR. KEITH: No, none whatever. I suppose that they feel that being in Ottawa at some distance away, it is harder to keep control. In Ontario, in the Ontario Heart Foundation, which is closer to the research worker, it allows more flexibility in the grant money.

COMMISSIONER SALTZMAN: I hope you will be able to bring me up to date on some of these things. You and I probably realize that I should know what I am going to ask you, but I don't. Is the Canadian Heart Society associated now with the Canadian Cardiovascular Society, does it grant any scholarships at the present time?

DR. KEITH: No, it is not a grantin-body, the Canadian Cardiovascular Society.

COMMISSIONER BALTZAN: That being the case, all these figures here that you have listed on page 9, you are only endorsing and recommending, but it would not necessarily come under the Canadian Cardiovascular Society in the way of distribution?

DR. KEITH: The members of the Society are mainly the individuals who implement the plan of research in heart disease in Canada, and therefore that is why they have felt it wise to come here to present this material.

COMMISSIONER BALTZAN: So that actually the fiscal body would be the Canadian Heart Foundation?

DR. KEITH: Yes, or the provincial Heart Foundation or the Department of National Health in Ottawa or the M.R.C. or N.R.C. or D.R.B., wherever the money for heart research is coming from.

THE CHAIRMAN: Thank you very much, Dr. Kelly and your associates.

DR. KELLY: Thank you, sir.

--- Luncheon adjournment.

CONSTITUTIONAL [illegible]: That points to a case, all these [illegible] that you have listed on page 2, you are only endorsing and encouraging, but it would not necessarily come under the Canadian Constitutional [illegible] in the way of distribution?

DR. WHITE: The members of the [illegible] are only the individuals who [illegible] the plan of research in mental illness in Canada, and therefore that is why they have felt it wise to come [illegible] present this material.

[illegible] the [illegible] body would be the Canadian Mental Foundation?

DR. WHITE: Yes, or the provincial [illegible] foundation or the department of national health in Ottawa or the M.A.C. or N.R.C. or [illegible], whichever the money for [illegible] research is coming from.

DR. [illegible] [illegible] [illegible].

[illegible]: Thank you, sir.

--- Luncheon adjournment.

dpw

--- On resuming at 2 p.m.

THE SECRETARY: Mr. Chairman, the next submission is that of the Canadian Mental Health Association, Ontario Division, which will be known as Exhibit 300, and Mr. Perry will introduce the members of this group.

--- EXHIBIT NO. 300: Submission of the Canadian Mental Health Association, Ontario Division.

SUBMISSION OF THE CANADIAN MENTAL HEALTH ASSOCIATION, ONTARIO DIVISION.

Appearances: L.W. Perry
Dr. J.D. Atcheson
C.T. Rousell

MR. PERRY: Mr. Chairman, I am accompanied this afternoon by Dr. James D. Atcheson, Chairman of the Scientific Advisory Committee of the Ontario Division, the Canadian Mental Health Association. Dr. Atcheson is also the Superintendent of Thistletown Hospital, an Associate in the Department of Psychiatry and lecturer at the School of Nursing, University of Toronto.

Mr. C.T. Rousell, M.S.W., is the Executive Director of the Ontario Division.

With your permission, sir, I intend to refer briefly to the preamble of our submission and then invite Dr. Atcheson to make submissions on our behalf.

May I specifically refer to paragraph 6, on page 3 of our submission and point out to you, sir, that the Ontario Division of the Canadian Mental Health

--- It resumed at 1 p.m.

MRS. SECRETARY: Mr. Chairman, the next submission is that of the Canadian Mental Health Association, Ontario Division, which will be known as Exhibit 4, and Mr. Perry will introduce the members of this

--- EXHIBIT 4 - 40: Submission of the Canadian Mental Health Association, Ontario Division.

SUBMISSION OF THE CANADIAN MENTAL HEALTH ASSOCIATION, ONTARIO DIVISION.

Appearances: D.W. Perry
Dr. J.D. Atchison
C.T. Konsati

MR. PERRY: Mr. Chairman, I am accompanied by Dr. Atchison, who is a member of the Scientific Advisory Committee of the Ontario Division, the Canadian Mental Health Association. Dr. Atchison is also the Superintendent of Thistletown Hospital, an associate in the Department of Psychiatry and lecturer at the School of Nursing, University of

Mr. C.T. Konsati, M.S.W., is the Executive Director of the Ontario Division.

With your permission, sir, I intend to read briefly to the members of our submission and then invite Dr. Atchison to make submissions on our behalf.

May I specifically refer to paragraph 3, page 2 of our submission and point out to you, sir, that the [illegible] of the Canadian Mental Health

Association has 19 Branches throughout Ontario and presently consists of some 5,200 active members. It is made up of citizens of Ontario who recognize the tremendous need for public education related to mental health, research, social rehabilitation of the mentally ill and to improve facilities directed towards alleviating the problems of mental illness. The sincerity of this relatively small membership is well demonstrated by the fact that some estimated 50,000 hours of volunteer time was directed towards the problem of mental illness by this group of citizens in the last year.

The Ontario Division considers it an honour and a pleasure to make submissions to this Commission. I now ask Dr. Atcheson to make those submissions on our behalf.

DR. ATCHESON: Mr. Chairman, our Association, in submitting this brief, felt that there were four major areas for consideration in attempting to build a better mental health program for Ontario. Those were listed, first, under Co-ordination; second, Research; third, Personnel and fourth, Education.

With your permission, what I would like to do is to read the recommendations of our Association submitted relative to each of those four headings. These are summarized in our brief under Conclusions, but I would like to enlarge on these conclusions, if I may.

First, our recommendations with regard to co-ordination.

[illegible] ion [illegible] 11 [illegible] throughout Ontario [illegible] [illegible]ly consists of some 6,200 active members. In [illegible] of citizens of Ontario who recognize the [illegible] need for public education relative to health, research, social rehabilitation of the mentally ill and to improve facilities directed towards alleviating the problems of mental illness. The activity of this relatively small voluntary association is well demonstrated by the fact that some estimated 10,000 hours of volunteer time was devoted towards the problem of mental illness by this group of citizens in the last year.

The Ontario Division considers it an honour and a pleasure to make submissions to this committee. I now ask Dr. Albeson to take these submissions on our behalf.

DR. ATCHESON: Mr. Chairman, on behalf of the association, in submitting this brief, I want therefore four main areas for consideration in attempting to build a better mental health program for Ontario. These are: [illegible]; [illegible]; research; training, [illegible] and [illegible].

With your permission, what I would like to do is to read the recommendations of our Ontario Division committee relative to each of these four areas. These are summarized in our brief on pages [illegible], but I would like to enlarge on those recommendations, if I may.

[illegible]

[illegible] consideration.

(24) 1. RECOMMENDATION: The Canadian Mental Health Association, Ontario Division, recommends that mental health programs should be operated by local or decentralized authority within a comprehensive provincial framework of regionally co-ordinated planning, funding and control of standards.

(25) 2. RECOMMENDATION: The Association wishes to point out the important part played in the prevention, recognition and management of mental illness by non-medical agencies, and recommends that religious, educational, welfare, legal and correctional bodies be included in all considerations of mental health programs, with continued specific efforts to increase communication and co-ordination of activities among them.

(26) 3. RECOMMENDATION: As an important initial step in implementing these recommendations, the Association urges that increased recognition and support be given to the indirect services of consultation, education, etcetera, which specialized mental health agencies are able to provide to other agencies. The process of providing such services tends in itself to bring about the increased communication and co-ordination which is needed.

(27) 4. RECOMMENDATION: To make co-ordination effective at all levels, the Association recommends that formal administrative provision be made for the participation of all interested groups in the planning and operation of services, by the establishment at local and regional levels of representative boards with operating authority. There should also be provision for

Mental Health Association, Bergen Division, [illegible] that mental health programs should be operated by local [illegible]

[illegible]

unofficial framework of regionally co-ordinated planning, finance and control of such programs.

(22) 2. COORDINATION: The Association wishes to point out the important part played in the prevention, recognition and management of mental illness by non-medical agencies, and recommends that religious, educational, welfare, legal and correctional bodies be included in all coordinated mental health programs, with continued specific efforts to increase communication and coordination of activities among them.

(23) 3. [illegible]: An important initial step in implementing these recommendations, [illegible] that increased recognition and support be given to the [illegible] of consultation, education, etcetera, which specialized mental health agencies are able to provide to other agencies. The process of providing such services tends in itself to bring about the increased communication and co-ordination which is needed.

(24) 4. ADMINISTRATION: To make co-ordination effective at all levels, the Association recommends that formal administrative provision be made for the participation of all interested groups in the planning and control of services, by the establishment [illegible] representative [illegible]

integration of activity among the several departments of the provincial government which deal directly or indirectly with mental health problems. And we are thinking specifically here of such departments as the Department of Health and Welfare or correctional and reform institutions, as well as in terms of the forensic problems.

(28) 5. RECOMMENDATION: Recognizing that SERVICE, TRAINING and RESEARCH are basic functions in all mental health programs, the Association would point out that the first cannot be carried out effectively unless the other two are adequately provided for. Concerning existing programs of staff procurement and training and of research and investigation in all the fields mentioned, the Association recommends that greater provision be made for co-ordination and intercommunication.

Under our second major heading on which we drew conclusions, that is on research, I would like, with your permission, to read the recommendations in this regard.

(32) 1. RECOMMENDATION: It is estimated that at present Canada spends one-quarter of one percent of its total health budget on research on mental illness and mental health (reference: CMA Journal, August 12, 1961). In the United States one percent of the health budget is so spent and it has been recommended that two percent of this budget would be appropriate. Acceptance of this rate of spending in Canada would mean an eight-fold increase. It would seem certain that it

integration of activity among the several departments of the provincial government which deal directly or indirectly with mental health problems. Apart from thinking specifically here of such departments as the Department of Health and Welfare or correctional and penal institutions, as well as in terms of the broader problems.

(iv) b. RECONNAISSANCE: Recognizing that CONSULT, TRAINING and RESEARCH are basic functions in all mental health programs, the Association would point out that the first can be carried out effectively without the other two are adequately provided for. Concerning existing programs of staff procurement and training and of research and investigation in all the fields mentioned, the Association recommends that greater provision be made for co-ordination and intercommunication.

Under our second main heading on which we draw conclusions, that is on research, I would like, with your permission, to read the recommendations in this regard.

(i) 1. ECONOMY VALUE: It is estimated that at present Canada spends one-quarter of one percent of its total health budget on research on mental illness and mental health (reference: CMA Journal, August 12, 1961). In the United States one percent of the health budget is so spent and it has been recommended that the amount of this budget would be appropriate. Increase of this part of expenditure in Canada would mean at most-[illegible] increase. It would seem certain that it

would require some time before this portion of the budget could be effectively spent on research on mental illness in Canada in view of the necessity of training or in other ways acquiring the necessary research personnel.

(33) 2. RECOMMENDATION: A substantial proportion of the total mental health funds available for research should be expended in the form of grants to individual research workers. To be most effective these grants should be for relatively long periods of time rather than subject to renewal on a year-to-year basis. In this regard, the Canadian Mental Health Association puts forward as an example its own National Mental Health Research Fund which makes grants to career research scientists for at least a number of years.

(34) 3. RECOMMENDATION: It is suggested that applications for grant funds and other administrative matters in connection with the promotion of research in the field of mental illness be dealt with in terms similar to those presently employed by the National Research Council.

(35) 4. RECOMMENDATION: Effective administration of grant funds will probably require the setting up of a special administrative group -- perhaps within the Department of National Health and Welfare, or perhaps within the National Research Council itself. At present, these funds are administered by a department that is primarily concerned with service responsibility which may account for the inflexibility in the terms of the grant and the apparent tendency to consider favourably

would require real time before this policy of a budget could be effectively put on paper to provide illness in Canada in view of the dependency of [illegible] in order we's acquiring the necessary medical care.

(33) i. [illegible]: A [illegible] of a proportion of the total medical health insurance for research should be earmarked in the form of grants to the [illegible] medical research worker. To be more explicit these grants should be [illegible] activity in some [illegible] of time rather than subject to renewal on a year-to-year basis. In this regard, the Canadian Medical Research Association urges Canada as a whole to [illegible] a [illegible] of [illegible] medical research [illegible] to encourage research activities for at least a number of years.

(34) j. [illegible]: It is suggested that [illegible] for grants [illegible] administrative matters in connection with the promotion of research in the field of mental illness be [illegible] to [illegible] similar to those [illegible] by the [illegible]

(35) k. [illegible]: [illegible] of [illegible] medical research [illegible] the [illegible] of a [illegible] administrative [illegible] within the Department of National Health and Welfare, or [illegible] the National Research Council itself. At present, there [illegible] [illegible] that is [illegible] concerned with [illegible] [illegible] the [illegible] and the [illegible]

only requests for training and research which have direct and immediate implications for service. We submit that this is far too narrow a concept of what is required for advance in our understanding of mental illness.

(36) 5. RECOMMENDATION: In addition to administering extra-mural grant requests, an agency such as the National Research Council might with good effect undertake its own intra-mural research program as it does not in a number of the other fields of science. Such an organization would have the advantage that interdisciplinary research among workers in the fields of neurology, biochemistry, physiology, psychiatry and psychology could be readily organized. Such a program does in fact operate and with apparent success within the National Institutes of Health in Washington.

(37) 6. RECOMMENDATION: It is suggested further that consideration be given to setting up research groups within service settings such as the Ontario Hospitals. At the present time the staff of these institutions are charged primarily with a service responsibility and inevitably this takes precedence over research. Our proposal is that there be research appointments to these staffs in the several disciplines, these individuals to have no service responsibilities whatsoever. Apart from the fact that they would have ready access to the material necessary in their research again the opportunity for interdisciplinary research would be provided.

(38) 7. RECOMMENDATION: With respect to

personnel, it seems clear that there will be a continuing shortage of qualified people. In view of this, it is urged that careful attention be given to support of programs designed to train people for research as well as for service in the several disciplines concerned with mental health. We would note in this connection that research grants made to individuals in universities for basic animal research as well as for research with children and adults adds not only to our basic knowledge but provides opportunities for training graduate students who may ultimately be attracted into one of the mental health professions.

Under the third major heading of Personnel, I would like your permission to read the recommendations that are made.

(46) 1. RECOMMENDATION: In addition to recommendations elsewhere in this Brief regarding economies to be effected by better co-ordination of existing services, we actively support the more popular short-term measures now being advanced to provide the necessary mental health personnel.

(47) 2. RECOMMENDATION: Our Association further supports the view that the problem of personnel shortages demands a comprehensive, Province-wide study on a continuing basis carried out by an adequately representative Commission and that this "Manpower Commission" might well be a responsibility of the interdepartmental authority referred to specifically under "Co-ordination".

The fourth aspect of our presentation

is that related to Education, and by this we are primarily referring to public education concerning the nature of the problem. The recommendations that are made under Education were:

(53) 1. RECOMMENDATION: The Association would strongly support the general principle of increased and improved information services to the public. To this end we support the view that there is a need for research into the effectiveness of our present methods of mass communication, in order to assist the positive changes they may create in the public's understanding of mental illness and its needs.

(54) 2. RECOMMENDATION: There is need for more inter-professional co-operation and technical and expert assistance in the preparation and dissemination of mental health education material.

These are the basic recommendations made by the provincial division of the Canadian Mental Health Association and are summarized under the four headings mentioned under conclusions in the brief submitted.

THE CHAIRMAN: Thank you, Dr. Atcheson. At the moment, Ontario, as in the other provinces, has full charge, full responsibility, for all mental health services and the financing of them, perhaps with the exception of some research grants.

Now, in connection with those grants, you refer to them at the foot of page 13, the top of page 14. Would you give us an example of just how this thing works, the system that you want changed in terms of your Recommendation No. 35.

in that related to Education, and by this means
mutually reflecting to public education concerning
the nature of the problem. The recommendations are
as follows under education head:

(53) 1. EDUCATION: The association
would strongly support the general principle of
increased and improved information services to the
public. In this we endorse the view that there is
a need for reorganization into its effectiveness of our
present methods of mass communication, in order to
assist the positive changes they may create in the
social understanding of mental illness and its needs.

(54) 2. FUNDAMENTAL: There is need for
more inter-relational co-operation and technical and
expert assistance in the preparation and dissemination
of mental health education material.

These are the basic recommendations
made by the providing a division of the Canadian Mental
Health Association and are summarized under the four
headings mentioned under conclusions in the brief
submitted.

Mr. CHAIRMAN: Thank you, Mr. [illegible].
At the moment, Ontario, as in the other provinces,
has full charge, full responsibility, for all mental
health services and the financing of them, perhaps
with the exception of some research grants.

Now, in connection with these recommendations,
you refer to them at the foot of page 3, the top of
page 4. Would you give us an example of just how this
change works, the sources that you have assumed in
your recommendation No. 3?

DR. ATCHESON: Without giving a specific example I think I could give a generalization.

THE CHAIRMAN: Give me a set up example if you like.

DR. ATCHESON: Research needs and the building of a research can often not be predicted within a few days or weeks or even months and to predict the course of one's research for one year ahead and to cut a deadline to be funded for this with the limitations modifies onesapproach in the period. You approach this going into the work of research with a limitation that often denies good research and the suggestion that is being made is that funds of this sort be invested in people, people called researchers, to give them the full right to the terms of the application itself. In other words, research beyond going to a person who is going ahead with such a program for a long period of time, investing in this person and the work rather than in a specific project which is the way research grants are awarded at the present time.

THE CHAIRMAN: With that in mind, what suggestion have you to make to meet the situation that arises from year to year in these early grants. As you appreciate, these arise from the fact that monies are voted by the legislature or by parliament from year to year and not for a specific term, it is only a yearly budget in the legislature and that is the only continuity there is. One legislature does not necessarily do the same as its predecessor. How are you going to overcome the situation by this continuing of grants and bursaries for research. This keeps recurring in the submissions

Dr. ALLEN: Without giving a specific example I think I could give a generalization.

THE CHAIRMAN: Give me a net to example if you like.

Dr. ATCHESON: Research needs and the funding of a research can often not be predicted within a few days or weeks or even months and to predict the course of one's research for one year ahead and to put a deadline to be funded for this with the investigator realizes unsuccessful in the period. You approach this going into the work of research with a limit for that often denies good research and the suggestion that is being made is that funds of this sort be given to people, people called research, to give them the full right to the terms of the application itself. In other words, research favored going to a person who is going ahead with such a program for a long period of time, investing in this person and the work rather than in a specific project which is the way research funds are awarded at the present time.

THE CHAIRMAN: With that in mind, what suggestion have you to make to meet the situation that exists from year to year in these early years. As you mentioned, these arise from the fact that monies are voted by the legislature or by use. Most from year to year and not for a specific term, it is only a yearly budget in the legislature and that is the over commitment there is. The legislature does not necessarily do the same as its predecessor. How are you going to overcome the situation by this continuing of funds and basic research. I'd keep returning in the subdivisions

and we are faced with the problem with the way governments operate and budget and provide money.

DR. ATCHESON: Recognizing the limited ability to predict a budget and how much funds will be available in the fiscal year by a government I believe the suggestion for what we are recommending is one of a foundation in which funds can be held and the funds can be meted out and it is not in any way connected with a fiscal year.

THE CHAIRMAN: We have the Canada Council of $100 million voted in one year of which the parliament vested itself of control of this money. Your suggestion is that has to be done in these other fields to get some continuity?

DR. ATCHESON: Somewhere in the terms of reference with some specific change related to the particular problem but in general terms related to the type of operation, yes.

THE CHAIRMAN: Now, recommendation 32, you speak of the operation of the research budget spent in Canada in terms of the proportion spent in the United States; is this figure both provincial and dominion or are you only talking about federal resources in each case?

DR. ATCHESON: The implication is it is a total fund available to a province a part of which would be obtained by dominion grant and part of which would come from the provincial treasury itself.

COMMISSIONER BALTZAN: Gentlemen, as members of the Canadian Health Association, Ontario

and we are faced with the problem with the way government operates and budget and providing money.

Mr. ATKINSON: Considering the fiscal capacity to provide a budget and how much funds will be available in the fiscal year by a government I believe the suggestion for what is the recommendation is one of a discussion in which funds can be held and the funds can be laid out and it is not in any way connected with a fiscal year.

THE CHAIRMAN: We have the Canada Council of $10 million voted in one year of which the land grant vested itself of control of this money. Your suggestion is that has to be done in these other fields that are some continuing?

Mr. ATKINSON: Somewhere in the terms of reference with some specific change related to the particular problem but in general terms, related to the type of recommendation, yes.

THE CHAIRMAN: Now, recommendation 32, you speak of the creation of the research budget event in Canada in terms of the uncertain event in the United States; is this future both governmental and religion or are you only talking about federal research in general?

Mr. ATKINSON: The intention is to have a total fund available to a province a part of which would be obtained by donation grants and part of which would come from the provincial treasury funds.

THE CHAIRMAN: Gentlemen, is moving to the Canadian Commissioner, Mr.

Division, you concern yourselves with the healthy minds of people as well as sick minds of people in the broader sense of the word. Do you find yourself engaged mostly in relation to offering all the health help you can to those who have crossed the border, if you want to use that term, or are you doing a great deal towards preservation of the healthy mind? Am I making myself clear?

DR. ATCHESON: I think the two points referred to by the Honourable Commissioner, it is very difficult to make a dichotomy between them in terms of positive mental health approach. The practitioner who offers his services to an ill person is bettering his own mental health. I think we all agree on that. We have only a limited knowledge of prevention of some types of mental disorder, many of these arising, of course, from social disorder or economic problems. These are often the fields causing the disorder. As well as this, the Association since its institution has concerned itself with improving the lot of those who are mentally ill and the plea, although not spelled out in one of the recommendations, is the plea that the mental patient be not treated as a second class patient but as a first class patient and whatever plans are made in the future for the care of the mental patient and their welfare that they be given the same care and consideration and financial assistance, if needed, as those who suffer from physical disorder.

COMMISSIONER BALTZAN: You speak of need for research and for the effectiveness of your

[illegible]

present methods of mass communication, what sort of information do you try to disseminate? You mention one thing about people understanding those who have not been of good health of mind and how society should reinstate them. What other things do you do in this mass communication?

DR. ATCHESON: Attempt to interpret the need for those suffering from mental illness, the incidence, the economic disability, the morbidity of these disorders to the public in a way that will dismiss some of the fears of antiquity of the insane and allow them to see it is something that is reasonable to contribute towards in terms of research, that it is the hopeful thing as well. To try do away with the concept of the word "image" because I think it is, without resorting to a cliche, we are concerned in modifying the image of the mental hospital and the image of the mentally ill person and by means of volunteers who visit at the hospitals and through their help with the mentally ill we see this is corrected. We do know from attempts to obtain money for research purposes on a national level that this image is far from completely accurately interpreted and so we would like this knowledge concerning using mass communication in the way that our colleagues in other areas of health, perhaps March of Dimes or the Cancer Foundation, they will contribute a goal towards which people will go.

The other area of public education is making the people, through knowledgeable use of interesting media where they have facilities that they

[illegible] mediums of mass communication, what sort of information do you try to disseminate? You mention one thing about people understanding those who have not been of good health of mind and how society should assimilate them. What other things do you do in the mass communication?

Mr. ANDERSON: Attempt to interpret the need for those suffering from mental illness, the incidence, the economic disability, the possibility of these disorders to the public in a way that will dispel some of the veils of apathy of the image and allow them to see it in something that is reasonable to contribute towards in terms of reason, that it is the decent thing as well. To try do away with the amount of the word "image" because I think it is without reporting to a cliche, we are concerned in modifying the image of the mental hospital and the image of the mentally ill person and by means of volunteers who visit at the hospitals and through their help with the mentally ill -- see this is correct. We do know from attempts to obtain money for research purposes on a [illegible] that the image is far from complete; accordingly improved and so we work [illegible] the way that our colleagues in other areas of health, perhaps [illegible] of [illegible] on the Cancer Foundation, then will contribute a good towards [illegible].

Mr. OTTAWAY: Lack of public education to reaching the people through [illegible] in [illegible] to make more [illegible] facilities [illegible]

can go to when they feel disturbed, the use of the general hospital out-patient, the out-patient attached to the mental hospital and the awareness that many patients admitted to mental hospitals are discharged within two months so that they need not be dismayed by seeking treatment. Again this is a matter of public information and education and we would only seek to improve any methods that we use at the present time.

COMMISSIONER BALTZAN: You seem to be leaning towards the side of the unhealthy people and I see in your preamble number 5 you say:

"The objectives of the corporation
"shall be to work for the conservation
"of mental health and for the improve-
"ment in the care and treatment of those
"suffering from nervous or mental
"diseases or mental deficiency and
"for the prevention of these disorders;
"to conduct or supervise surveys of
"the care of those suffering from mental
"diseases ----"

This brings me back to the original question, how much in the way of public information, public education or other programming in your organization for the conservation and keeping of minds of the people healthy?

DR. ATCHESON: Part of this would come under the heading of rehabilitation an attempt to rehabilitate and assist a person who has been ill back toward normalcy.

can go to when they feel disturbed, the use of the [illegible] hospital, the [illegible] to the mental hospital and the awareness that many patients admitted to mental hospitals are discharged within two months so that they need not be dismayed by seeing treatment. Again this is a matter of public information and education and we would only seek to improve any methods that we use at the present time.

COMMISSIONER BALTZAN: You seem to be leaning towards the side of the unhealthy people and I see in your preamble number 5 you say:

"The objectives of the corporation "shall be to work for the conservation "of mental health and for the improve- "ment in the care and treatment of those "suffering from nervous or mental "diseases or mental deficiency and "for the prevention of these disorders; "to conduct or supervise surveys of "the extent of those suffering from mental illness ——?

This brings me back to the original question, how much in the way of public information, public education or other programming in your organization for the conservation and keeping of minds of the people healthy?

MR. MACDONALD: Part of this would come under the heading of rehabilitation an attempt to rehabilitate and assist a person who has been ill back toward normalcy.

COMMISSIONER BALTZAN: I am thinking of the individual who might get that way before he gets that way, where he comes in rehabilitation.

DR. ATCHESON: We know in this regard that in actual statistics no one person has any immunity to mental disorder. The period in his life when this disorder might appear may vary from infancy to old age and again we would, through public education, like people to recognize that preventive steps can be taken. Sometimes this is done by an adult who recognizes it in a child and he directs this child towards assistance. Sometimes it is in the adult himself who may recognize, as I pointed out, by sharing with others and by being a "do-gooder" which is not a shameful thing to be, he may improve his own mental health. By recognizing mental health or dishealth or disease in a sibling, in a wife or child they may bring that person to a frame of reference again where preventative measures can be taken. I realize I am avoiding your question, is there a part of the mental health approach we may use. We do not know that this is true except in the particular general sense contributing to one another we remain in a homostatic or comfortable state in any society and I think this is mental health.

COMMISSIONER BALTZAN: In other words, you have not got ground rules yet?

DR. ATCHESON: For given mental disorders, no, for some, yes.

COMMISSIONER BALTZAN: For people who have not got disorders but may acquire them?

COMMISSIONER [illegible]: I am speaking of the individual who wants to get that way before he gets that way, where he comes in rehabilitation.

Mr. ATHERLEY: We know in this regard that in actual statistics no one person has any immunity to mental disorder. The period in his life when this disorder might appear may vary from infancy to old age and again we hold, through public education, like people to recognize that preventive steps can be taken. Sometimes this is done by an adult who recognizes it in a child and he directs this child towards assistance. Sometimes it is in the adult himself who may recognize, as I pointed out, by studying with others and by taking a "do-gooder" which is not a scientific thing to do, he may improve his own mental health. My recommendation regarding disability or disease in a relative, in a wife or child they may bring that person to a frame of reference again where preventative measures can be taken. I realize I am avoiding your question, is there a part of the mental health approach we may use, we do not know that this is true except in the particular general sense. Perhaps to one authority we turn in a hopeless or comfortable state in any society and I think this is another problem.

COMMISSIONER PAUTZKE: In other words, you have not put proper rules yet?

Mr. ATHERLEY: For mental health disorders, no, for sure, yes.

COMMISSIONER [illegible]: I'm sorry, we have not understood that very well.

THE CHAIRMAN: Might avoid them, not acquire them.

COMMISSIONER BALTZAN: We are so pre-disposed that we are liable to acquire them.

DR. ATCHESON: Let me give you an example and this is one I know something about. Twenty to thirty years ago there were admitted to the hospitals many, many cases of general paresis, or mental disorder due to syphilis. This went on for a few years and then the medical researchers found penicillin which worked very well and nowadays we rarely have any general paresis patients but the relationship of research, education and personnel, the whole thing becomes obvious and shows what can be done when working together as a co-ordinated whole.

COMMISSIONER GIRARD: Mr. Chairman, Dr. Atcheson: You speak in paragraph 3 of personnel and specifically of the shortage of personnel and again specifically of social workers, nurses, et cetera. Under your recommendation regarding the shortage of personnel you speak also of more imaginative ways of giving bursaries, more liberal and imaginary ways of giving bursaries and other assistance. What do you mean by more imaginative bursaries?

DR. ATCHESON: Well, we have felt that we must recognize that as one way of dealing with personnel shortage is to make good use of the areas that are not within the disciplines of psychology, psychiatry, nursing services, et œtera, more liberal and imaginative bursaries. I think an example I would

MR. [illegible]: Might would them,

not [illegible] very,

[illegible] MR. [illegible]: [illegible] on

[illegible]-minded [illegible] be [illegible] to [illegible] them.

[illegible] [illegible]: Let me give you an

example and this is one I [illegible] on [illegible]. Twenty

to fifty years ago there were adopted in the [illegible]

[illegible], [illegible] [illegible] I [illegible], on [illegible]

due to [illegible]. This went on for a few years and

then the [illegible] [illegible] [illegible] [illegible] [illegible]

worked very well but [illegible] [illegible] have [illegible]

[illegible] [illegible] in the relationship of [illegible],

[illegible] and personnel. The [illegible] [illegible]

[illegible] [illegible] what can be done [illegible] [illegible]

as a [illegible] [illegible].

Dr. [illegible]: [illegible] [illegible] 3 of [illegible]

and [illegible] [illegible] the [illegible] of [illegible] [illegible]

[illegible] [illegible] of social [illegible], [illegible], or [illegible],

[illegible] your [illegible] [illegible] [illegible] the [illegible] of

[illegible] [illegible] [illegible] [illegible] [illegible] [illegible]

[illegible] [illegible], more [illegible] and [illegible] [illegible]

[illegible] [illegible] [illegible] [illegible] [illegible] [illegible].

[illegible] [illegible] [illegible] [illegible] [illegible]

[illegible] [illegible]

[illegible] [illegible]: [illegible], we have [illegible]

[illegible] [illegible] [illegible] that is [illegible] [illegible] [illegible]

[illegible] [illegible] to [illegible] [illegible] [illegible] [illegible]

[illegible] [illegible] [illegible] the [illegible] [illegible] [illegible] [illegible].

[illegible], [illegible] [illegible], [illegible], [illegible], [illegible] I

[illegible] [illegible] [illegible] [illegible]. I think [illegible] [illegible] I [illegible]

like to quote, a specific example and one with which I am familiar is in dealing with a hospital or in-patient treatment. We know it is difficult to get personnel who know how to look after the situation of a disturbed child, putting him to bed, getting him up, feeding him, living with him during this period when he is being examined, corrected, researched or trained.

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On this basis presently we have in Ontario a course for child care workers in which the individual is being trained either for one or two years and recognizes he may well, at the end of that time, go into child care work in some other area. I would think further imaginative bursaries which would provide economic help while the individual was approaching the mental health field would be extremely worthwhile, in the fields of nurse's aide, probation officers and many other who work with the human problems, by heavily subsidizing, if you will, their efforts through a period of concentrated curriculum and training.

COMMISSIONER GIRARD: Thank you very much.

COMMISSIONER STRACHAN: Mr. Chairman, Dr. Atcheson, referring to the recommendation in Paragraph 37: "At the present time the staff of these institutions are charged primarily with a service responsibility and inevitably this takes precedence over research". When you speak of service responsibility do you mean treatment responsibility and should not that take precedence over research?

DR. ATCHESON: Again the dichotomy is a difficult one to make. If the service one is rendering is inadequate because of lack of knowledge, it is service as far as one is able, it is an aspirin tablet for a headache without looking to see if there is a brain tumor. It seems to me it is proper to provide service as far as one is able, but it is abundantly necessary to provide people to take time to find causations and thus

improve service. Until we reach the level when we can equate the methods we use with positive results, then we will need research to improve them. If we see only the service side we will never improve the situation.

COMMISSIONER STRACHAN: Then you go on to say in the next sentence: "Our proposal is that there be research appointments to these staffs in the several disciplines, these individuals to have no service responsibilities whatsoever". Is this practical? Would there not be a conflict between the research worker and the staff on some occasions?

DR. ATCHESON: In my opinion it is unlikely. The ability of the service-oriented person to see the need of research is almost always present. I would think sometimes the hard-working person involved only on the service might see the researcher as a daydreamer, a person who lives in an ivory tower. This is prone to happen anyway and it depends on good communication in dispelling this improper concept. I don't think one would get this where they complemented each other through their operating efficiency.

THE CHAIRMAN: You say on Page 4, Paragraph 9: "It is in the opinion of the Ontario Division of the Canadian Mental Health Association that this provides ample evidence --- that was the discussion in the House of Commons and the McNaughton Resolution that the problems of mental illness must be assigned the highest priority in the examination of the total health needs of our nation". Do you want to spell that out a little more in terms of say, the concept upon which we hear the most

and which apparently is the subject of a lot of public discussion, that is physician service is something to occupy the whole field in the press and so forth etcetera, at the moment.

DR. ATCHESON: Mr. Chairman, the impasse in the time....

THE CHAIRMAN: We are vitally concerned with priorities in the health service field.

DR. ATCHESON: In using the McNaughton proposition as a parallel, as a way of substantiating this claim contained in Hansard many of the members came out supporting the question of mental disorders. For those of us who work in the field of mental illness, with mentally ill people, we were already very aware of this, the disability involved in the various forms of mental illness, the need for more hospital beds, the sense of antiquity where the mentally ill person had been seen as someone different who was financed and substantially cared for in terms of hospitalization in a different way and thirdly that we recognize, perhaps, the increase of these problems at two ends of the scale. The first one in infancy --- childhood because the number of children are increasing, and at the other end of the natural history of mankind in geriatrics because we are able to get man to live much longer, but he falls prone to an increasing number of illnesses. Not only is the problem as it exists of major importance, but secondly we can predict it will increase at both these age spans, age levels. So that this, in and of itself, would seem to substantiate this being the most important health matter

in the Dominion today. In my profession, the medical profession, we are aware of our limitations of getting at the cause of many forms of mental illness. It is much more limited than many other disorders. This however, is not a need of great pessimism as within the last two decades many major illnesses have been controlled. We would anticipate recognizing the problem of mental illness as the largest problem in public health, but with the increased interest in research and some of the recommendations made in this brief that would make major break-throughs in the care of mental disorders, how it can be controlled, the need of hospital beds and this disability can come under control as well.

COMMISSIONER BALTZAN: Since that report has there been some form of break-through, especially the 1951 report that recommends 11,416 beds for mental cases in Ontario -- since that time we have had a decline in the requirement for the bed accommodation in the mental hospitals.

DR. ATCHESON: Perhaps a decline in the request for more mental hospital beds, but increased requests or demands or appreciation that there be other forms of management. The utilization of the small hospital and the utilization of the general hospital for treating mental illness is important, special hospitals be needed --- this has been the way it has gone. The claim for a large number of beds quickly produced has perhaps been changed to the idea let's make this type treatment available to the individual in the community. I don't think it is affecting the question of disease,

but I think we have found or discovered a more preferable approach to it than simply building larger and larger mental hospitals which very few people at the present time would agree with doing.

COMMISSIONER BALTZAN: In other words, you have, perhaps, just as many cases only more of them are ambulatory?

DR. ATCHESON: I think that is quite true, and the use of drugs has contributed greatly to the keeping of the patient ambulatory and not hospitalized.

THE CHAIRMAN: Thank you very much, Dr. Atcheson and associates. We ourselves have assigned very, very high priority to the subject of mental illness. We have some special studies underway, as you know, and what you have submitted here this afternoon and what we will have from the Canadian Mental Health Association will be of value to our research people and ourselves. Thank you very much.

THE SECRETARY: The next submission is that of the Canadian Mental Health Association. It will be known as Exhibit 301. They have also filed with me the Patterns of Care which will be known as Exhibit 301A and interim reports 1 to 6, which will be known as 301B.

S U B M I S S I O N O F

THE CANADIAN MENTAL HEALTH ASSOCIATION

---EXHIBIT NO. 301: Submission of the Canadian Mental Health Association.

---EXHIBIT NO. 301A: Patterns of Care.

---EXHIBIT NO. 301B: Interim reports 1 to 6.

APPEARANCES:

MR. I. DUBIENSKI
DR. J. D. GRIFFIN
DR. RHODES CHALKE

MR. DUBIENSKI: Mr. Chairman, I am National President of the Canadian Mental Health Association. I am honoured today to be accompanied by Dr. Rhodes Chalke of Ottawa who is a member of the Committee on Mental Health Services of the Association's Scientific Planning Council and Dr. J. D. Griffin of Toronto our General Director.

I would like to make a few preliminary remarks, Mr. Chairman. This submission of the National Organization comes on the heels of nine Provincial submissions that have been made by our Associations, each of which have made various representations to you. I am not going to try to document their appreication of the problems of mental illness and disability in each of the Provinces. During the course of these it is my understanding

---[illegible], M.P. Operation of the Canadian Mental Health Association

---[illegible], M.P. Liberty of Speech

---[illegible], Colin Interim report [illegible]

Adjournment

MR. [illegible]:
[illegible]
[illegible]

MR. [illegible]: The Chairman, I am [illegible] Department of the Canadian Mental Health Association. I am honoured today to be accompanied by Mr. [illegible] of Ottawa who is a member of the Committee on Mental Health Services of the [illegible] Advisory Committee [illegible]

[illegible] like to make a few [illegible] remarks. Mr. [illegible] this morning [illegible] presentation based on the [illegible] of some [illegible] problems that have been [illegible] in our [illegible], and [illegible] some [illegible] suggestions to you [illegible] the government [illegible] [illegible] of mental health [illegible] [illegible] [illegible]. Briefly, in order of these it is my [illegible]

and I am advised by their groups certain questions were asked as the submissions were made and they were referred to our national office with the hope that probably they could come up with some answers which weren't forthcoming at the Provincial level. It would be redundant on my part, I believe, to say any more about the operation, I am sure, in the nine provinces that have been presented. You have been made fully aware of the scope of the organizations and the work that is being done. During your travels across the country I am sure you have experienced much the same as I did. I have just finished a trip on behalf of the Association. I have visited the major cities across Canada and I have found a tremendous interest and a very great public awareness of this problem of mental illness, particularly, with reference to the inquisitiveness and the appreciation of the persons representing the mass media, the press and so forth. I have met with a great number of them and in all instances they have shown great interest and expended a great amount of time in discussing the matter with myself, and very kindly and I think, very fairly presented problem as we see it. The proposed recommendations we have made, the recommendations in this submission are based mainly on the findings of our Committee on Mental Health Services which we appointed some years ago with the chairmanship of Dr. J. S. Tyhurst of which Dr. Chalke was a member. After some years of deliberation and research and careful consideration they came up with a new concept and new principles concerning the treatment of mental illness. It is on the principle that have been evolved by that

Committee that our submission is primarily based. I would ask Dr. Chalke to proceed to the recommendations that we have made as they reflect this new concept.

THE CHAIRMAN: I would like you to feel free, Dr. Chalke, as you do to expand on those areas where you think it is needed, the places and points we have been looking at, have asked for information. Anything you wish to fill in we would be very grateful for.

DR. CHALKE: Our brief, Mr. Chairman, is prepared with a number of sections leading to recommendations, and the recommendations are summarized on page 3.

I will review those, but first I would like to draw attention to Chapter III, which is the central theme. This central theme is really the keynote of the brief, and all the recommendations deal either directly or indirectly with this theme. This is basically that mental illness should be dealt with in precisely the same organizational, administrative, and professional framework as physical illness, and this was one of the keys in the report on the mental health services. The specific recommendations, the first is that a substantially increased appropriation be designated by the federal government for programs of public information and education in the field of mental health and that these programs be developed in collaboration with the provincial governments and the voluntary associations.

The reason for this recommendation is that social action in this field seems to require a certain amount of public information, and if we do not make the public aware of the situation that it entails, it seems hard to get the kind of community backing that is needed to get any plan forward, particularly if we try to put the care of mental illness in the community, because it has fallen to a community now to consider itself responsible for these needs, and because these needs are expensive no voluntary organization can undertake

to educate the public on behalf of a government that is trying to get social action going in this field, so we feel this is going to need some backing through educational activities of the government, to make the public aware of it before a program can go forward.

The second recommendation is that the mental health services be integrated with the physical and personnel resources of the rest of medicine.

This means bringing the care of the mentally ill back into the community, back into the general hospital particularly, and the professional care coming from physicians, nurses and other technical staff, who identify themselves with the general health services of that community.

The third recommendation is really a corollary to this, that general hospitals be encouraged to provide psychiatric services and that in the larger hospitals, that is over 200 beds, psychiatric units or sections should be established.

Now, there are some 50 of these general hospital units in Canada. The figure varies between 50 and 80, depending on what you call a unit, but there are 50 discreet units that are taking care of 40% of all admissions for mental illness across Canada that require hospital care, so though they represent a small percentage of the total of all psychiatric beds, they are caring for a significant proportion of all mental illness.

The fourth recommendation is that the wide range of psychiatric and mental health services be

[illegible]

co-ordinated so that the patient may receive appropriate help through all phases of his illness without interruption.

This is to overcome the present situation, if I may illustrate what can happen. Somebody in Toronto could become psychiatrically ill, and go to a general practitioner who refers them to a private consultant in psychiatry, who may see the patient in his office. The patient may then need hospitalization. If this psychiatrist happens to be on the staff of a general hospital he may take care of the patient there, but if the patient is sicker than this he may have to go to an Ontario Provincial Hospital, in which case he has to lose his doctor and have a new doctor. As he goes through this large psychiatric hospital he may go on various wards of the hospital, as his condition progresses. In each of these he may have to change doctors. He then may go back to the out-patient clinic, and rather than make it Toronto we might make it a place some distance away. At this stage he may have been in hospital a couple of years, lost his job, and lost his medical insurance. He goes back to his community, and cannot go to his own doctor, but the provincial mental health clinic, so he may have as many as seven psychiatrists during the course of this illness. This is one reason why we urge that the services be co-ordinated, to provide continuity of care, and services should be co-ordinated with each other, so that there are not great gaps in service, and duplication in services, and other areas being completely uncovered. Say a Forensic

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some distance away. At this stage he may have been in
hospital a couple of years, lost his job, and lost
his medical insurance. He goes back to his community,
and cannot go to his own doctor, but the provincial
mental health clinic, so he may have to wait as long
as this visits during the course of this illness. This
is one reason why we need that services be co-ordinated,
a tremendous continuity of care, and somehow should be
provided to him each step, so that the care
is done in sequence, and hospitalization in services, and
other other medicine unknown. So a family

Clinic may be required in a community, and you have lots of geriatric services, but no forensic services, and there should be lots of group planning within a community to co-ordinate these services, and the wide range is the tremendous range required from childhood to geriatrics to forensic problems, alcoholism, people with acute depressions that need short term hospitalization, people that need longer hospitalization, with say a special environment, a family setting, in order to recover.

Now, to try and achieve this, recommendation five is that the psychiatric treatment services be established in centres of population on a regional and decentralized basis.

At the present time very few of our provincial mental health services are necessarily sited in terms of the medical water-sheds of the community. They are often sited for other reasons, political reasons, economic reasons in terms of giving employment to staff, and not necessarily where people normally go when they get sick. So that one of the first things is that all mental health services should be near the homes of the people who are ill, to prevent them being dislodged from their homes, and having to go 70 miles for treatment, which would be unthinkable if they had an orthopaedic disability, or a sick child.

THE CHAIRMAN: Is that the fact?

DR. CHALKE: People go 70 miles away.

THE CHAIRMAN: No. What you say is you are going to put the hospitals where there are the

greatest areas of population because we don't know in advance who is going to be ill, and who is not going to be ill. The only real test is to put the hospital accessible to the greatest number, and from that concentration will come the greatest number of patients.

DR. CHALKE: This I would say is true on the whole, just as our big general hospitals are in metropolitan areas. Other communities have general hospitals though of one or one or two hundred beds. The general policy has been to isolate mental hospitals.

THE CHAIRMAN: I follow that completely, but even accepting your recommendation number two and three and so forth, even these 200-bed hospitals are going to be some miles apart, except in the metropolitan areas.

DR. CHALKE: That is true. I think that is inescapable. There will be large areas of relative isolation, and there will be possibly only one mental hospital available in a community, say in Newfoundland. We cannot have everybody near home. The decentralized concept is tied in with this, that it is important if we can to put the management of these hospitals back into the hands of the community, as are our general hospitals now. That they would be more responsive to local needs. That they would give more opportunity for the professional community to become involved with them, and plan them, and not look upon them as a posting within a provincial service. The people working there would be people living there, and more important that the hospital itself would involve

in terms of the Board of Governors and so on people interested in the community, and doing their best for that area, or region, whatever it was.

Recommendation six is that increased budgets and improved facilities be provided for the post graduate training of psychiatrists, social workers and psychologists.

Recommendation number seven is that training arrangements be greatly strengthened for the other mental health professional personnel, particularly occupational therapists and nurses.

This is simply the fact that we have a tremendous relative lack in all these fields, and part of the reason for this is that particularly in terms of post graduate training, that people are getting relatively older, and they have to have a living wage of some kind to substain themselves through the post graduate period, and we are now in the situation where we lose a great many potential people in this field at the training level to the United States, because they are able to pay at the training level more than a qualified person in these fields can get in Canada, once they have got their full accreditation.

We also need here, this is not just a matter of budgets for the individual, it is a matter that the training facilities are very short. There are not enough schools with the training opportunities to in fact produce as many people as we need.

The problem of nurses is gradually being modified a little by the fact that most R.N. schools

now in parts of Canada anyway require psychiatric affiliation, but many of these affiliations are not in hospitals which in fact teach the kind of psychiatric nursing which we hope would be operative if this type of plan were carried out.

Recommendation number eight is that special efforts be made to improve the undergraduate training and post graduate experience in psychiatry for the general practitioner.

It has been variously estimated that anywhere from 30 to 70 per cent of the general practitioners' patients have more or less of a problem related to emotional problems, or psychological problems of one sort or another.

COMMISSIONER BALTZAN: What were those percentages again please?

DR. CHALKE: Various surveys have varied from 30 up to 70 per cent, depending on the place where the survey was conducted and the kind of practice that it was engaged in, but certainly a third would I think be a minimum that most of the surveys have found here.

COMMISSIONER BALTZAN: And the majority of these can be handled by the physicians and the general practitioners?

DR. CHALKE: The majority of them are being handled that way, because of the magnitude of the numbers, but one gets the impression in talking to general practitioners, or when one has a post graduate course they request more information, and acknowledge

an inadequacy in their training in this area.

It is only in the last five years, or six years, that there have been departments of psychiatry in every medical school in Canada, so we are only just beginning to get the people in general practice who have been exposed to much in the way of under-graduate teaching.

There is a subsidiary recommendation in the report here that a qualification in psychiatry should be a requirement in order to practise medicine in this country. At the present time the qualifying examinations are set by the Medical Council of Canada, and psychiatry is not yet a required examination in the Medical Council of Canada examinations. This is not of terribly great concern in terms of our own graduates, because we know that they all get a final examination at university level for an M.D. degree, but in terms of the high proportion of physicians coming to practise in this country who didn't graduate in Canadian universities, we feel that an adequate degree of knowledge and skill should be demonstrated as a requirement to be licensed to practise medicine in this country.

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Again, this question relating to our general theme, that psychiatry should be like the rest of medicine, in that in the practice of medicine generally the practitioner more or less chooses his sphere of activity, depending on his own interest, if he wants to spend most of his time with an industrial organization. These are things that can be determined, whereas the present situation in psychiatry - when I tried to illustrate to you when I talked about the disjointed patients, the psychiatrist is disjointed, too, because he is given one segment of the patient, he sees the patient in one section of the illness, but he doesn't have the satisfaction of looking after the patient throughout the period of his illness. This is one of the problems of adequate staffing of one of the government hospital services, we believe.

Recommendation X, page 3a:

"That a stepped-up recruiting campaign be undertaken to encourage suitable young people to enter the mental health careers."

This is simply suggesting that we get out into the high schools and the colleges and try and lure as many people into this area where we feel there is a tremendous shortage and we know we are in tremendous competition with all the teachers and other professions which are short, too. But we feel possibly there is a lack of knowledge, the average student in high school just doesn't bump into psychiatry every day, so we have to make a special effort to acquaint the young student

with what is involved in being a psychiatrist or psychiatric nurse.

Recommendation XI:

"That the amount of federal government support available for research in mental illness and mental health be increased by 10 - 20% annually and that this money be assigned to a special Mental Health Section of the Medical Research Council to administer."

This, I imagine, sir, you have heard many times, I think, that we spend roughly 5 cents per capita in Canada on psychiatric research and in the United States they spend roughly 50 cents per capita on psychiatric research. This is simply a plea for the financial support.

Now, it is phrased in this way, increasing annually, because it will take a great number of years to produce the people to carry out the research, and it would be very embarrassing if somebody gave all we needed next year because we couldn't cope with it. So it needs to be done slowly and it needs some change from the current arrangements by which most of the support for research, other than private research funds or foundations or the C.M.H.C. funds, which are relatively small; most of these come through federal-provincial grants and these have certain restrictions upon them in that they must be acceptable to a province, which makes it sometimes difficult to do national research because you must find some province

which will pick this up for you. So the recommendation is that the Medical Research Council might be a good body through which to make these funds so that it would be separate from any direct service, that it would be able to dispose of this money in Canada, it would get the best pay-off for the money.

In addition, we should like to add to this recommendation or spell it out more fully in regard to one particular point, and that is to carry out research particularly aimed at evaluating what this brief and other briefs have put forward. Various people have said we should undertake care of the psychiatric wards in the hospital or we should set up units for adolescents. It is very important that these social changes in the care of mental illness be looked at critically so if we get on to a good thing, we get on to it very soon and other people can follow the pattern, and if it fails to prove things we should also know that soon so we don't go to any expense.

So we would like to plead for a strong evaluating facility. Whether this be a central government, federal responsibility or Medical Research Council or the provinces would take this on; we are not specific about it as long as somebody looks critically at any changes in psychiatric care.

Recommendation XII is:

"That the mental health research programs in Canada emphasize the importance of developing personnel and careers in research as well as

facilities."

This particularly refers to the point I made under Section XI regarding the problem of the research grants being annual. You have to dream up a project, support it and you get word back in April you can start in July. In the meantime you have to find somebody, and they want somebody in for the new project next year. This is the kind of research associateships which N.R.C. have set up which would be capable of handling this budget by government which are normally of a tenure of five or ten years, the associateship is granted by N.R.C. grants.

But a man who becomes deeply involved and exceedingly expert in analyzing the E.E.G.'s, differentiating in mental disorders and he wants to make a career of studying mental disorders, this is the type of order that this highly specialized research work requires.

Recommendation XIII, which changes the theme here and deals with legislation:

"That the provincial governments be encouraged to review and amend mental health legislation so that administrative procedures for mentally ill patients concerning the admission to hospital and the function of the public trustee or equivalent will, as far as possible, be similar to those for the physically ill patient."

I am sure the Commission is aware each province has its own laws governing the admission of patients to the mental hospital, and some of these are cumbersome, it makes it difficult to admit a mental patient at 2 o'clock in the morning, and some of them are unnecessarily restricting in grading in that they take away a good many civil liberties which would not necessarily be required by the patient's illness and which could well be retained by the patient during a period of hospitalization.

Such things as taking away people's right to drive a car, right to vote, to possess funds, to make legal contracts, make mortgage payments and so on, can all be taken away because he is admitted to a mental hospital. If he goes into a general hospital none of these things are generally done.

The British have come a long way in this regard. Some provinces have done bits and pieces in their amendments, where they are in a patchwork state, and we feel that a general review could be made of this topic and a model legislation could be set up having a more adaptable method of admitting patients.

THE CHAIRMAN: Which may be a job for the Uniformity Committee?

MR. DUBIENSKI: It would be, Mr. Chairman. We will have to refer it to them in the next meeting in Halifax.

DR. CHALKE: Recommendation XIV also deals with legislation:

"That the federal government be

I am sure the Commission [illegible]

[illegible] are [illegible] our long overwhelming [illegible] and [illegible] [illegible] to the mental hospital, and some of them are [illegible], it makes [illegible] to [illegible] months. [illegible] at [illegible] in the morning, and some of them are unnecessarily [illegible] in [illegible] in that they have [illegible] and [illegible] liberties which would not necessarily be required by the patients life [illegible] and which could well be restored to the patient during a period of hospitalization.

[illegible] things as taking away person's right to drive a car, right to vote, to possess firearms, to make legal contracts, make marriage arrangements and so on, can all be taken away, because he is committed to a mental hospital. It goes into a general hospital room of [illegible] [illegible] and generally done.

The minister has come a long way in this regard. Some provinces have done away and [illegible] in their [illegible], where they are in a [illegible] state, and we feel that a general [illegible] could be made of this topic and a model legislation could be set up having a more [illegible] method of admitting patients.

MR. CHAIRMAN: [illegible] may be a [illegible] the [illegible] [illegible]

MR. [illegible]: It would be, Mr. Chairman. We will have to [illegible] it to them in the next session in [illegible].

MR. CHAIRMAN: [illegible] Commission [illegible] some [illegible] with legislation.

[illegible] that the [illegible] [illegible] is

urged to amend the Immigration Act and certain words in the Criminal Code and Penitentiary Act in order to bring up to date the wording and interpretation concerning mentally disordered persons."

There are still words such as "lunacy", "insanity" and I know that these still have a very direct legal connotation which cannot be taken away. For example, in regard to the Immigration Act, if people come to Canada and are admitted to a mental hospital, they face the possibility of being returned to their own country, whereas if they go to a general hospital, with the same diagnosis, this will not happen to them.

So we think that the wording of the Act may be brought up to date in that regard.

Recommendation XV deals with children. Although we are most woefully short in Canada in regard to psychiatry, we are worse off in regard to children. We recommend:

"That properly staffed child guidance clinical services be provided so that there is one out-patient or school based clinic and one residential psychiatric treatment centre (15 - 20 beds) for each 100,000 total population."

At the present time this is our greatest lack in Canada in terms of clinical services.

[illegible] to impose the Law [illegible] and
[illegible] a [illegible] in the "[illegible]
[illegible] and [illegible] [illegible] [illegible] [illegible]
[illegible] [illegible] to [illegible] the [illegible] and
[illegible] [illegible] [illegible] [illegible]
[illegible] [illegible] [illegible] [illegible]."

[illegible] are still too [illegible] as "[illegible]",
"[illegible]" and I know that these [illegible] have a very
[illegible] [illegible] [illegible] which cannot be taken away.
For example, in regard to the [illegible] Act, if
people come to [illegible] [illegible] [illegible] [illegible] to a mental
hospital, then [illegible] the possibility of being returned
to their own country, whereas if they go to a general
hospital, with the same disease, this will not happen
to them.

[illegible] think that the account of the
act may be brought up to date in this manner.

[illegible] [illegible] [illegible] [illegible] with children.
Although we are most [illegible] about [illegible] in regard
to [illegible], we are [illegible] [illegible] in regard to child [illegible]
[illegible] [illegible].

"[illegible] [illegible] [illegible] [illegible] [illegible]
[illegible] [illegible] services be provided [illegible]
[illegible] there is one [illegible] [illegible] [illegible]
[illegible] of [illegible] and one [illegible]
[illegible] [illegible] [illegible] [illegible] [illegible] [illegible]
[illegible] [illegible] for [illegible] [illegible] [illegible]
[illegible] [illegible]."

[illegible] the [illegible] [illegible] this is [illegible]
[illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible].

Recommendation XVI:

"That a planned program of increasing annual expenditures for mental health services be accepted as necessary if an adequate standard of treatment and care is to be developed."

This is simply the statement that it is going to cost more money to bring into effect any of the proposals here and it couldn't possibly be done with the same amount being spent now for psychiatric services. To carry out these services it is going to increase in direct cost, but the estimated cost is roughly now some 250 million dollars, 300 million dollars, which we pay in direct costs, whereas 600 million dollars per annum loss of income, and we would hope, on the basis of studies and statistics that are currently available, that increasing this to, say, 450 million dollars would materially reduce the 600 million dollars indirect cost of getting people back to work much sooner and keeping them at work much longer.

Recommendation XVII is again very closely tied to the central theme of this brief:

"That any plan of comprehensive hospital and medical treatment insurance must include comprehensive psychiatric hospital and treatment services for the mentally ill without discrimination or exclusion."

I don't think I need enlarge on that.

THE CHAIRMAN: I suppose the emphasis there is that you want the Hospitalization and Diagnostic Services Act amended accordingly?

DR. CHALKE: Yes, amended to apply to mental hospitals and that any government participation in any medical care insurance plan would ensure that the psychiatric services were covered.

THE CHAIRMAN: That that type of discrimination be not carried forward ---

DR. CHALKE: Into a medical care insurance plan.

THE CHAIRMAN: Thank you very much, Dr. Chalke.

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COMMISSIONER BALTZAN: In speaking about general hospitals and hospital units for psychiatric cases that is about 30 or 40 beds, I presume?

DR. CHALKE: That is the average.

COMMISSIONER BALTZAN: Some are units and some sections but they are built in institutions and not segregated areas these 40 or so instances you have in Canada?

DR. CHALKE: They are segregated as much as the department of paediatrics or the department of surgery, they are areas within the hospital. In most cases they are a part of the main hospital building but in some cases they may be in existing buildings on the grounds of the hospital.

COMMISSIONER BALTZAN: These larger hospitals are usually in larger areas and therefore it means it is some distance travelling for people. I wonder whether three or four beds set aside in a small hospital of 25 to 50 beds could not be used for such a purpose as, say, acute agitation cases or an acute depressive case that could, within three or six weeks be reoriented, restored. Would that not be a good thing for these small hospitals to accommodate people so as to keep them closer to home especially, as you stated earlier, in a good many of these cases they may be handled on the part of the G.P.?

DR. CHALKE: A good many people would support you. A good many of these hospitals would be staffed by two or three general practitioners you would not have a psychiatrist available on a resident basis.

COMMISSIONER BALTZAN: Not all these cases, I am given to understand, always need the benefit of a specialist of psychiatry?

DR. CHALKE: I think a good many, at least from being on the receiving end of people who go to small general hospitals first, I am sure a lot of cases are being treated in this way. We get the ones the G.P.'s send us. They will call up from a town 50 miles away and say "I have this patient and he did not get better in three weeks". However they might say"I had Mrs. So-and-So in here for three weeks and she is gone home again". I am sure a good many of these people are being treated by general practitioners.

COMMISSIONER BALTZAN: That is no different from a heart case that stays away and then is referred. You think that could be useful and meet a need?

DR. CHALKE: I think so.

COMMISSIONER BALTZAN: You make reference here to the private professional service, non-medical types, do you remember that? In the larger centres there are often a number of non-medical people who have had special training in psychology, medical and personal guidance and they are consulted by many people who have problems. with reference to child management, family disharmony and so forth.

DR. CHALKE: Yes.

COMMISSIONER BALTZAN: Are there many such in Canada? I know it is a common event in the United States?

DR. CHALKE: I might refer this to Dr. Griffin who is probably more aware of the private practitioner of psychology and social work in Canada.

DR. GRIFFIN: Yes, it is on the increase. From the information we have it is slightly on the increase in Canada. There are more psychologists now established in what they call private practice than was the case ten years ago. This is not commonly encountered except in the large centres, Montreal, Toronto and Vancouver, perhaps, almost never in smaller cities. It is not a rapidly increasing phenomena in Canada but it is present.

COMMISSIONER BALTZAN: They are acceptable and welcome to the ranks?

DR. GRIFFIN: Many of them work on referrals of patients or clients from doctors, the doctors refer children, parents with children who have problems relative to school, to emotional disturbances relating to selection of his vocation and all that sort of thing. These things are commonly referred to these people and they do a reasonably competent job.

COMMISSIONER BALTZAN: They are well trained academically?

DR. GRIFFIN: I think where they would get into trouble is when they attempt to treat a person who is really sick in our sense of the term mental illness. I think in that case they would be incompetent, if I might use that word, to treat a person who has a serious depression, for instance, or serious agitated disturbance and excitement. I think most of them

would be very quick to say "We are not interested in trying to deal with this kind of case".

COMMISSIONER BALTZAN: In other words they seem to be lacking a certain amount of clinical training along with their basic ---

DR. GRIFFIN: That is right. Several of these psychologists who have established themselves in private practice have associated themselves with a psychiatrist or a medical person interested in psychiatry on a working sort of colleagueship basis. These people have a fine professional experience in that kind of work relationship.

COMMISSIONER BALTZAN: They are also frequently integrated with your hospitals?

DR. GRIFFIN: Sometimes that is true.

COMMISSIONER BALTZAN: And the psychiatric units have the evaluation of children?

DR. GRIFFIN: That is right.

COMMISSIONER BALTZAN: I am interested in your reference to the Verdun Hospital in Montreal, one of a kind and you say this is a non-profit hospital administered by local and lay board of governors. That is a private institution, or is it?

DR. CHALKE: It is a private hospital in the same sense, I would think, as St. Michael's General Hospital here is a private hospital. However, it is a non-profit hospital, its board is appointed by a self-perpetuating body. It had to have approval by the Ministry of Health of Quebec.

COMMISSIONER BALTZAN: How is it financed?

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trying to deal with this kind of case".

COMMISSIONER SALTZMAN: In other words
they seem to be [illegible] a certain amount of [illegible]
[illegible] along with their basic ---

DR. QUINTON: That is right. Several
of these psychologists who have established themselves
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[illegible] on a weekend some of [illegible] basis.
These people have a fine professional experience in
their view of work relationship.

COMMISSIONER SALTZMAN: They are also
frequently interested with young hospitals?

DR. QUINTON: Sometimes that is true.

COMMISSIONER SALTZMAN: And the
[illegible] people have the evaluation of children?

DR. QUINTON: That is right.

COMMISSIONER SALTZMAN: I am interested
in your relationship to the Hudson Guild, in Hartford,
one [illegible] and you say this is a non-profit [illegible]
administered by local and [illegible] board of [illegible]. This
is a [illegible] institution, is it?

DR. QUINTON: [illegible], [illegible] [illegible]
in the [illegible] [illegible]. I would think, [illegible] [illegible]
[illegible] [illegible] is a private [illegible], however,
it has a [illegible] [illegible], it [illegible] is [illegible]
by a [illegible] [illegible] board. It [illegible] to [illegible]
[illegible] [illegible] of [illegible].

[illegible] [illegible]. [illegible] is in the [illegible]

DR. CHALKE: Among other ways I know of, Dr. Griffin may enlarge on this, they get a per diem grant from the Province of Quebec for each patient that is in there as a public patient.

COMMISSIONER BALTZAN: The patients pay for going in?

DR. CHALKE: Not necessarily, they can be indigent and, in fact, by far the largest proportion of patients there do not pay anything. You can go in to Verdun, however, as a private patient, they have a private pavilion where you can go in and pay but by far the largest number of patients are supported on a per diem grant from the Province of Quebec.

COMMISSIONER BALTZAN: What are the special merits or advantages of this type of institution?

DR. CHALKE: Well, the great merit is that it is decentralized and, therefore, you have a group of citizens for whom this is of great concern. You may have 10 or 20 people, the head of a bank note company or a bank who are interested in making this the best possible hospital they can make it. They are free to utilize and call upon charitable foundations to have public appeals to put a new special building for occupational therapy which is difficult to do if you have provincial hospitals run through a centralized office. That is the greatest advantage.

COMMISSIONER BALTZAN: They do a fair amount of research?

DR. CHALKE: Yes.

COMMISSIONER BALTZAN: And clinical research?

DR.CHALKE: This they are able to do again because they, as an independent board, can go and ask the Rockefeller Foundation for X dollars in order to carry out research which a provincial mental hospital cannot. The superintendent of a provincial mental hospital cannot run out and get money from any private foundation in this way.

COMMISSIONER BALTZAN: Thank you for helping me in the distinction.

COMMISSIONER VAN WART: Dr. Griffin, the research grants you spoke about, grants for certain purposes and other grants more or less open are there research grants in mental health for mental libraries, medical libraries?

DR. GRIFFIN: It is my understanding that some of the federal mental health grants may be used for the purchase of books for libraries. This used to be the case, I am not certain whether it is still true.

DR. CHALKE: If a new unit is opened up usually there is a capital grant for purchasing basic reference books but you cannot now acquire continuing subscriptions?

COMMISSIONER VAN WART: Proper research cannot be done without a proper medical library, an adequate medical library, that is true is it not?

DR. GRIFFIN: Absolutely, and it is one of the great needs that has often been expressed by

[illegible]

[illegible]

[illegible]

research in Canada, ones that we have talked to in trying to arrive at the findings in this brief expressed the need for research libraries in the field of mental health. It has even been said by some enthusiasts that there is not one such library presently in Canada. This may be from excessive zeal but certainly we are lacking in this generally.

COMMISSIONER VAN WART: Your Association would recommend money being applied to purchase adequate medical libraries?

DR. GRIFFIN: Yes.

COMMISSIONER VAN WART: Now, we have heard quite a lot in your brief about the change from custodial care to psychiatric rings and home service and so on and the advantages of this system. However, we have heard none of the disadvantages of it; is it not true that in cases of emotional illness that the return home early of the psychiatric patient is going to have a certain emotional effect on the family?

DR. CHALKE: That certainly is a possibility, sir, and it is true we are hearing more about this as you have indicated but surely this indicates also the need for more extensive and intensive community mental health service. The after care for patients who have left the mental hospitals or psychiatric units in general hospitals in Canada are in the very early stages of beginning. There is probably more work needed in developing, more money, more planning needed in developing adequate after care rehabilitation, sheltered industrial setting and that sort

of thing for X mental patients in our country than any other single aspect of this whole field with the possible exception of work with children, as Dr. Chalke has emphasized.

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COMMISSIONER VAN WART: It is based on the fact mental health should be given almost the major priority.

DR. CHALKE: This also brings up the question about the need of studying this particular kind of question. It follows on what happens if you change some of the arrangements for the care of the mentally ill. For example in England they have been studying Worthing. They have been keeping mental patients out of the mental hospitals. While they have been doing that they have been taking a good sharp look at the effect it has on families and children and so on. We cannot really answer your question because we have never studied the impact of this particular thing on a community.

THE CHAIRMAN: Thank you very much, Mr. Dubienski, Dr. Chalke and Dr. Griffin. We are building up our library of knowledge.

MR. DUBIENSKI: Thank you for the opportunity.

THE CHAIRMAN: We are grateful to you.

MR. DUBIENSKI: Thank you indeed, sir.

THE SECRETARY: The next submission is that of the Ontario Psychiatric Association. Dr. Miller will introduce his members to the Commission and present his recommendations. It will be known as Exhibit 302. They have also sent along various Appendices number from I to XII which will be known as Exhibit 302A.

S U B M I S S I O N O F

THE ONTARIO PSYCHIATRIC ASSOCIATION

---EXHIBIT NO. 302: Submission of the Ontario Psychiatric Association.

---EXHIBIT NO. 302A: Appendices Nos. I to XII.

APPEARANCES:

DR. A. MILLER,
DR. C.A. CLELAND,
DR. H.W. HENDERSON,
MR. R.B. SLOANE,
DR. A. DOYLE,
DR. K.G. GRAY,
DR. W. MITCHELL.

THE CHAIRMAN: Dr. Miller?

DR. MILLER: Yes, sir. May I present the members of our group: On my right Dr. Gray; Dr. Henderson; Dr. Cleland; Dr. Sloane; Dr. Mitchell and Dr. Doyle. Shall we proceed?

THE CHAIRMAN: If you will.

DR. MILLER: This is a brief from the Ontario Psychiatric Association. I would like to read the recommendations and I believe you have all got a copy of our brief.

It is recommended that:

1. Mental illness be recognized as the most serious of all health problems in terms of:

   I. The numbers involved

   II. The disablement induced

   III. The cost of the care

   IV. The gaps in our scientific knowledge

2. Greater knowledge be sought in all areas. Juvenile and adult delinquency, drug addiction, mental retardation, the disorders of children and the aged, are urgent and growing problems, whether assessed in dollars or human unhappiness. Research is the only way to find new and better answers to these questions. Although the flow of money into mental health research has increased it it still relatively far less than the amount devoted to physical health.

3. Facilities for training of professional personnel in the Mental Health field should be increased.

4. Treatment for mental illness should be provided on the same basis as for physical illness.

5. Treatment of mental illness should be included under the Hospital Insurance and Diagnostic Act (Federal Bill - 320) in the same way as for physical illness.

6. Prepaid medical insurance plans should adequately cover mental illness.

7. Priority should be given to the expansion of psychiatric facilities.
The services of such facilities to be centred, preferably, on local general hospitals, and providing in and out patient facilities, including adequate non-residential adult and children services.

8. Psychiatric facilities should operate under by-laws similar to public general hospitals.

9. Rehabilitation should be fostered through halfway houses, sheltered workshops, and day and night hospital accommodation.

10. The community should develop greatly increased facilities for the care of the aged, through home help, meal services and the provision of hostels and small homes.

11. Legislation, relevant to the mentally ill, should be reviewed.

THE CHAIRMAN: Thank you, Dr.Miller. Do you wish to make any observations? I don't know, you just came in when the discussion was going on the Canadian Mental Health Association. Are there any general observations you wish to make at this time, either yourself or any of your associates?

DR. MILLER: Regarding the whole field?

THE CHAIRMAN: Yes.

DR. SLOANE: I would like to pick up the echo of Dr. Chalke's comment. We are still in the stage of having attitudes to the various techniques, if you like, in dealing with psychiatric patients, whether in mental hospitals, general hospitals and so on. This is one of the most pressing needs for investigation, I think, the operational research to find out whether there are good, bad effects associated with various ways of treating psychiatric patients.

COMMISSIONER BALTZAN: Did you get the one question earlier as to what is being done in terms of positive help?

DR. SLOANE: I am afraid I wasn't here.

THE CHAIRMAN: That mental illness be recognized as the most serious of all health problems in terms of -- would you care to comment on whether you

should just stop with problems period?

DR. MILLER: Well, if we stop at that point, I don't believe we have been able to pin-point to some extent the way in which it is really a serious health problem. I think one has to expand and develop this point so it has some relevancy to the actual situation. I think the four points we have made tend to direct attention to the way in which it is a serious health problem, most serious health problem.

THE CHAIRMAN: Are you in a position to make comparative statements as to the seriousness of mental illness in relation to the plight of those who are suffering from mental illness in relation to the plight of those suffering from physical illness insofar as being taken care of is concerned? Are you satisfied that they are being well taken care of? Are they being amply taken care of in Canada today?

DR. MILLER: We are talking for Ontario, of course.

THE CHAIRMAN: Well, Ontario likes to suggest that they speak for Canada. I don't mean the medical people, just Ontario as a place from which I don't come.

DR. SLOANE: I consider they are not as relatively well taken care of as physical illness is.

THE CHAIRMAN: Let me put it this way, we have --- "We", the "Canadian people", have a given amount of money to spend on service, on health service, on improving health service. Where do you say that money should be spent, on the physical health field,

or the mental health field, additional money.

DR. MILLER: I would think that our group would feel there should be no difference, that the money should be spent for all sick people to an equal extent.

THE CHAIRMAN: Do you think that physically ill people, and if you do, say so, that the physically ill are, shall I say, as inadequately served as the mentally ill of Canada at the present time?

DR. MILLER: I don't think I would think so.

THE CHAIRMAN: Either speak up or do something about it, unless you don't understand me.

DR. MILLER: I think the physically ill people are looked after for the most part. I think the people who are mentally ill, I think a good deal of improvement could take place in the quality of care. I think that more facilities and more money, more attention has to be directed in order for the people who are suffering from this kind off disability to have the kind of care which I think it is possible to provide for them.

THE CHAIRMAN: You say in Number 6: "Prepaid medical insurance plans should adequately cover mental illness". Do you mean by that in the same way as these plans cover physical illness?

DR. MILLER: Yes, sir.

THE CHAIRMAN: Without differentiation, discrimination or anything?

DR. MILLER: That is right.

THE CHAIRMAN: Merely because the

matter was referred to in terms of insurance coverage, and not dealing with the therapy of the situation, because I don't know anything about it, but would you care to comment on the proposition that was put forward by the insurance companies here last week that in any prepaid insurance plan it is desirable that there should be a co-insurance feature up to as much as 50% of the cost of psychiatric service where they do not make the same recommendation for physical illness.

DR. MILLER: Would you care to answer, Dr. Mitchell?

DR. MITCHELL: No, because I don't know what co-insurance is.

THE CHAIRMAN: Co-insurance is that the patient will pay part of the bill.

DR. GRAY: Mr. Chairman, I would suggest that the whole of this brief would say we don't agree with that statement.

THE CHAIRMAN: You don't. I must say it did not make sense to me either. It was suggested that this is good therapy. The insurance companies were suggesting that. It would be the same as if I suggested it. Perhaps they know more about it than I do. If I was receiving psychiatric treatment it would help me if I had to pay half of my bill, what do you say on that as a proposition in terms of prepaid insurance if we were discussing making insurance available to everybody regardless of pre-existing condition?

DR. SLOANE: I think the medical or scientific theorum on which it is based, psychotherapy

does you good if you have to pay for it, has been confounded by studies. That is one of the areas we know it does not apply. I think if it is irrelevant to the narrow field of psychotherapy it is quite irrelevant to the major field of psychiatric care.

THE CHAIRMAN: Thank you very much.

COMMISSIONER BALTZAN: Gentlemen, still looking at your first statement, which frightens me to read:

"Mental illness is to be recognized as the most serious of all health problems",

in terms of four items.

My first question in that connection is: would you say that half of all illnesses in Canada are mental illnesses, in terms of numbers involved?

DR. MILLER: It is difficult to get an accurate figure, but taking it on the basis of the information that we do have, I would say yes to that. For example, the number of people who are hospitalized in Canada for mental illness equals the number of people hospitalized for all other reasons.

COMMISSIONER BALTZAN: That is not a very good comparison. One is hospitalized for two, three or four years, as of the past, and in the turnover of general hospitals, that is, I don't know how many times, maybe ten times as much. That sort of statistical comparison does not apply.

DR. MITCHELL: The costs are equal.

COMMISSIONER BALTZAN: I am not interested in costs.

THE CHAIRMAN: Have you made that statement with forethought, because we have been told that the costs, the money spent on physical illness is four times as much per unit as on mental illness.

DR. MITCHELL: Well, in a book on the

National Health Service, by Abell, Smith and Tipman, they found that a certain percentage of the gross national produce was directed towards all medical care...

THE CHAIRMAN: Their figures were not in relation to Canada.

DR. MITCHELL: No, but it was a survey of total cost in a service, and more than half of those were directed towards the mentally ill.

THE CHAIRMAN: You will have to accept that those figures are not valid at all in Canada. In terms of the present-day figures from the Department of National Health and Welfare, it is four to one, $5 per day as compared to an average of twenty.

DR. MITCHELL: That is how they spend it now.

THE CHAIRMAN: Yes, that is how they spend it now. That is what we are talking about, now.

DR. HENDERSON: If I may take exception to the question, two, three or four years is a great exaggeration.

THE CHAIRMAN: I think your figures are 30 or 40 days?

DR. HENDERSON: That is getting closer to it.

COMMISSIONER BALTZAN: I was thinking about the old-fashioned asylums.

DR. HENDERSON: The incidence of mental disorder, there are many statements to the effect that two out of three patients consulting a general practitioner have some emotional factor, either

related to a physical disorder, or this is the main cause of their disability.

COMMISSIONER BALTZAN: Well, let's speak not academically, but the statement as it applies to the nation. There is a component in all other illnesses that is of an emotional nature. Do you classify that as a mental illness? Would an individual like that be counted among those who suffer from mental ill health? What is included in this broad term of mental ill health?

DR. MILLER: Any factor which affects the person's functioning and state of well-being.

COMMISSIONER BALTZAN: It might be for an hour, or a day, on account of business or of weather?

DR. MILLER: Yes.

COMMISSIONER BALTZAN: I am thinking of people reading that. This is one of the most serious things that affects this nation. That is the thing that bothers me at the moment. Is it really true?

DR. MILLER: Well, we say it is. We say in terms of all the people in Canada who may be sick at any given time, this represents a large segment of the population, of the illnesses that people are suffering from.

THE CHAIRMAN: I think it has been said to us on a number of occasions that of all those in hospitals this afternoon, 45 out of 100 are in mental illness beds. Some have said 50, but we are

told that the more correct figure is in the neighbourhood of 45.

COMMISSIONER BALTZAN: These same conditions that we are speaking of, perhaps I could go so far as to call them, say, the borderline cases. What is the essential part of their treatment as being so-called people suffering from mental illness? What is their form of treatment? One is mentally disturbed because he has a broken leg. The proper treatment is to get his leg mended and get him back to work, and then his emotional troubles are over. And that one is mentally disturbed because of difficulties at home. Then, if some counsellor, or some interested body, sees that that element is straightened out, then he is relieved of his tensions and anxieties, and is back into operation, and is immediately relieved of being counted among this number of people suffering from mental ill health. Right?

DR. MILLER: No.

THE CHAIRMAN: I don't know that the Commission exists to educate Dr. Baltzan.

COMMISSIONER BALTZAN: I am thinking in terms of the need therefore for treatment and rehabilitation. Some of the things that you are stressing here, that these are, as they appear to me, then not altogether within the aegis or the domain of, say, the mental therapist.

THE CHAIRMAN: Perhaps we can reach it this way, Dr. Baltzan, that if they say that the 45 out of 100 who are in hospital this afternoon in a

mental institution, how many of them are there with broken legs and so forth? That is not the people you are talking about at all?

DR. MILLER: No, that is right.

THE CHAIRMAN: They are in hospital because they have been put there. Somebody has diagnosed them as being suffering from mental illness?

DR. MILLER: Because they have an illness which is interfering with their ability to function.

THE CHAIRMAN: Besides those then, there is this category that Dr. Baltzan is talking about. Those that have suffered some financial loss or some relative has come to visit them and they would like to get rid of them?

DR. MILLER: Do you want us to talk about this?

THE CHAIRMAN: I would like you to talk about it.

DR. MILLER: I don't think that the people you are talking about would be psychiatric problems at all. I think these are people who are experiencing the emotional reactions of ordinary life situations, or extraordinary life situations perhaps.

The people we are talking about are the people who have an emotional disturbance, which, in itself, is interfering with their functioning. Not necessarily the situation which they may be reacting to. It is not the broken leg, and it is not the financial problem. It is the way the person is reacting, or

adapting to it, which determines whether the person is ill or not.

COMMISSIONER BALTZAN: So these people who are severely disturbed constitute half the sickness in Canada?

DR. MILLER: We are including a number of categories.

COMMISSIONER BALTZAN: Yes, on a wide plane?

DR. MILLER: Yes.

COMMISSIONER BALTZAN: Priority should be given to the expansion of psychiatric facilities and I think we have heard a good deal about that. Now, what is being done, or what would you recommend in the way ---

THE CHAIRMAN: I wonder if you gentlemen are really talking about the same thing? You are talking about half the sick people; relatively half of them. That does not make them half the population.

COMMISSIONER BALTZAN: Yes, the sick population.

THE CHAIRMAN: Yes, it is a far different thing than half the population.

COMMISSIONER BALTZAN: Yes, I think I phrased my question originally, half the sick people, not half the population of Canada.

"Priority should be given to the provision of psychiatric facilities providing hospitals, patient facilities, etc." What work, again for our information, is under your aegis in the way of research?

Is research under your Association going on in Ontario?

DR. SLOANE: There are studies into the causes of the psychosis of old age, and the causes, if you like, of alcoholism. Are these the sort of things you have in mind?

COMMISSIONER BALTZAN: Yes.

DR. SLOANE: Yes, they are all variously taking place, including in this province, yes.

COMMISSIONER BALTZAN: And that is part of the activities of your organization, or members of your organization?

DR. SLOANE: Yes, sir.

COMMISSIONER GIRARD: Under this same paragraph on priorities, you give priorities to facilities. Now, among facilities, what priorities would you give to day care and night care? I ask you these questions because I am very much impressed with the work that is being done in Montreal with the patients in day care and night care, and it seems to me that if more of this were done we could prevent a lot of patients going into the institutions, being completely hospitalized or institutionalized.

Would you rate this as high priority in your facilities?

DR. SLOANE: Yes, we consider this is a high priority, and it is probable that this will cut down the need for hospital admission, and cut down the duration of illness, if a person needs to be admitted to hospital.

I want to stress that we still do not

have the facts and figures to know that this is a better way of treating the patients, although we strongly believe that we would urge that we are still finding that out. We couldn't prove it, but we believe it is a good way, and it is being done to an increasing amount in this province, a considerably increasing amount.

COMMISSIONER GIRARD: Would you say this is in the field of preventive medicine, and that anything we can do in preventive medicine in mental health will give rewards later on?

DR. MILLER: Very much so.

DR. DOYLE: I think the point should be made here, Mr. Commissioner, that priority centres for day and night care, that these are associated with the general hospital. Priority, I think, still needs to be toward seeing that our centre of health for the community, that is the general hospital, is assuming a much greater responsibility than has been true in the past for the treatment of psychiatric patients.

COMMISSIONER GIRARD: Did you say these are not associated with general hospitals?

DR. DOYLE: They are. What we haven't got yet anywhere near adequately is the general hospital unit, or the general hospital service that is contributing to the treatment and prevention of psychiatric disorder in the community.

This is, I think, a striking thing; that here is a serious sort of illness in all its phases, and except in certain isolated, or certain centres,

little has been done towards recognizing the general hospital as the logical place to assume the responsibility for this community medical problem.

COMMISSIONER GIRARD: But as a rule they wouldn't -- you say where you have day and night care is usually in a hospital that also has a psychiatric section?

DR. DOYLE: Yes, but it is on getting the facilities.

COMMISSIONER GIRARD: It is above that. It is something more?

DR. DOYLE: Yes, very important.

COMMISSIONER STRACHAN: Mr. Chairman, I wonder if we could have Recommendation No. 3 enlarged upon?

DR. SLOANE: There is a considerable dearth of professional personnel in all areas. That is delineated in the body of the brief and we consider that to start with, psychiatric training, there is a great need for an extension of the graduate training and undergraduate in this area. That this probably, at the graduate level, needs to be taken special cognizance of by possibly some increased university money for this person, and this extends through all the other branches, social work, occupational therapy, nursing, psychology, all of which are not well-represented in varying degrees.

COMMISSIONER STRACHAN: Irrespective of numbers, then the training facilities in the mental health field should be increased?

DR. SLOANE: Should be increased.

COMMISSIONER STRACHAN: Irrespective of the number of personnel?

DR. SLOANE: I don't quite follow you.

COMMISSIONER STRACHAN: Irrespective of the number of personnel that now exists, you say that the facilities for training in the mental health field should be increased?

DR. SLOANE: Yes.

THE CHAIRMAN: Have you any further comments to make, gentlemen, any one of you?

DR. CLELAND: One of the points we would like to bring out, which is brought out pretty well in the brief, is the fact that the present method of caring for emotional break-down, mental illness, in a great many parts of the country is to treat that person some 100 miles or so from his home, and we feel very strongly about that. That is not the treatment for, say, physical illness. There is a general hospital around the corner or certainly within an hour's drive of the patient's home. We would like to see community facilities developed to the extent that treatment for a psychiatric illness, for a severe psychiatric illness is available near the patient's home where he doesn't have to lose contact with his community, with his family or possibly with his job or with his employer. These things are all highly important, and this is the reason

why we have directed our report in the nature of providing community facilities, something right in the patient's own back yard, as it were, and we have gone a bit along this way and we expect that this will be developed very highly in the next few years, we hope.

THE CHAIRMAN: Dr. Cleland, what is the distribution of your psychiatrists in Ontario?

DR. CLELAND: By and large the psychiatrists in private practice are in the larger centres.

THE CHAIRMAN: How do you see this ideal that you have been expressing being worked out in practice, if that is the actual situation as to the location of your specialists in psychiatry?

DR. CLELAND: I think there has been a great change in the last ten years, in one thing in the acceptance of psychiatrists by other members of the medical profession and their use in consultation and in treating various problems, and I feel that this is going to progress and that there will be plenty of room for psychiatrists in the smaller centres than we have now.

THE CHAIRMAN: Now, I come back to this matter of some form of prepaid coverage for all illnesses, including psychiatric services. Have you any special position to take in that regard, or are the specialists in psychiatry satisfied to be bundled in with all the other physicians and paid on the same tariff basis?

DR. CLELAND: Personally I think we

would be very satisfied, Mr. Chairman, that is to be bundled with all the other physicians and paid in the same manner.

THE CHAIRMAN: That is on a fee-for-service basis?

DR. CLELAND: Yes.

THE CHAIRMAN: Is that the general practitioner's fee or the specialist's fee?

DR. CLELAND: Naturally I think it should be the specialist's fee, because a specialist in psychiatry is as trained as any other specialist is.

THE CHAIRMAN: How do you visualize the patient reaching the psychiatrist? By referral from the general practitioner?

DR. CLELAND: Very frequently it would be.

THE CHAIRMAN: Is this the pattern of practice you think should obtain?

DR. CLELAND: Now, I am a mental hospital superintendent. Possibly we should have one of the practitioners in psychiatry answer that question.

DR. DOYLE: Ideally I think that the referral of a patient to any specialist, whether he is a psychiatrist or some other specialist, should come from this patient's personal physician. In practice, as times have changed, I believe often a citizen knows when he needs something that is special and he shouldn't perhaps -- it shouldn't be insisted that he go to see one doctor to have him referred to another doctor, when he knows what he requires. But I think ideally we

should have a specialist who knows his needs.

THE CHAIRMAN: I wonder if you have any thoughts on that question put to Dr. Cleland, because it has been represented to us, and certainly to me personally, that a psychiatrist would starve with that type of remuneration. While the general practitioner or a specialist may see 15 or 20 patients a day, the psychiatrist, if he is doing a good job, will see four or five or six maybe.

DR. DOYLE: I think there are two things enter into this. One is that there is certainly -- I don't believe there are any reliable figures about what it does cost to see that people do get proper psychiatric care, we just don't know, and I think the insurance companies are away out of line in their fear that such coverage would ruin the company financially, it is just not so.

THE CHAIRMAN: This is a sort of fear that appears to be in the background.

DR. DOYLE: Yes. What we do feel is that it isn't as expensive as it may seem, that people are not making the effort to provide this coverage because of this fear.

Only recently, in the last few weeks, they have produced a suggested plan for the payment for psychiatric treatment.

THE CHAIRMAN: On what basis?

DR. DOYLE: This is on a fee-for-service basis largely.

THE CHAIRMAN: Oh what basis as regards

to other medical services?

DR. DOYLE: They are limited.

THE CHAIRMAN: In what way?

DR. DOYLE: Limited in the number of consultations which may be had, the amount that they will pay for a given service. Let's say a given service is $15.00, they will pay $5.00.

THE CHAIRMAN: Are the doctors afraid it will cost P.S.I. too much?

DR. DOYLE: Certainly P.S.I. feel it will cost too much. Some of them, and P.S.I was actually the first, have undertaken at least to do something about covering psychiatric illness, and other insurance companies have seen fit to follow in line to a limited degree.

THE CHAIRMAN: Is this a manifestation of the age-old prejudice of mental illness being carried into the medical field?

DR. DOYLE: I believe it is repercussions from ignorance, yes.

THE CHAIRMAN: You say that they even now have limitations, they have not accepted the principle that mental illness is an illness like any other and should be treated accordingly?

DR. DOYLE: Yes.

THE CHAIRMAN: The fundamental concept of your submission here today?

DR. DOYLE: That is what we have submitted.

COMMISSIONER BALTZAN: Let's take, as

an example, the average fee in your field. How would it compare the fee, say, for an operation, if somebody had to pay $200.00? How does it compare? Take a case that is referred to you and you have to have continuation treatment, the sum payable, say, roughly over the average, would it amount to very much more than a major surgical operation?

DR. DOYLE: No, I wouldn't say it would, sir. If patient were under care for, say, two months -- I can only speak from personal experience and that of a few of my colleagues -- seeing the patients every day and having some long sessions with the patient as well, about two months, would likely cost him as far as the psychiatric fee is concerned anything from, say, $150.00 to $300.00 or something like that. Perhaps others wouldn't quite agree with this, but it is in that area. Whereas a surgical operation, and it doesn't have to be a very big one, would certainly be $200.00 and it would be done in, say, an hour or two hours or whatever the case may be. I think psychiatrists as a whole are working on a basis which is extremely reasonable, and perhaps they are underrating their value.

THE CHAIRMAN: Why can't you convince your own organization?

DR. DOYLE: We are convincing them; we are working at this all the time.

COMMISSIONER VAN WART: Your psychiatric illness may recur, in the surgical patient it may not.

DR. DOYLE: Yes. I have just, for instance, seen a patient in a general hospital in this

city something like 16 months. Most of my patients, our patients, are out of the hospital in 30 days. So you can't make generalities about psychiatry.

You spoke also of distribution of psychiatrists. In 1940 I would saythere were two, I believe, in this city who at least allowed themselves to be called psychiatrists; there were others who practised psychiatry. I think there are something in the neighbourhood of 100 who are in private practice in metropolitan Toronto. Most of them are affiliated with local work --

THE CHAIRMAN: One to about 20,000?

DR. DOYLE: They are contributing to community affairs. But now in towns of 15,000, 25,000 psychiatrists are appearing who are doing a community job of practice in places like Peterborough, which was mentioned, and even smaller places. So that there is this new trend towards providing medical treatment, whether psychiatric or otherwise, of providing psychiatric care as part of a community part of a problem in community medicine.

COMMISSIONER BALTZAN: Isn't it also true that you are increasingly more in demand on the part of the patients themselves than every before. There was a time when one was suspected with too much of his imagination, he felt he was wrongly understood. Now a great more people go to psychiatrists than originally because they suspect they have such difficulties that demand a psychiatrist. Isn't there an increasing demand on the part of the individual patients?

DR. DOYLE: Yes, there is.

COMMISSIONER BALTZAN: Which is a reversal of the situation some years ago insofar as the public image is concerned.

DR. HENDERSON: This is something that is particularly apparent to me in planning and assisting the development of mental health clinics in the province. The demand has increased tremendously in the last few years. As a matter of fact, of the 24 services that the provincial government happens to operate, over half of them were established in the last ten years, which is some indication of the trend you speak of.

COMMISSIONER BALTZAN: And people have lost their inhibitions?

DR. HENDERSON: Yes, it is much more readily accepted as an essential element of medical care. No question of that.

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dpw

DR. SLOANE: Mr. Chairman, I would like to add a tailpiece; as psychiatry is accepted in this way and the natural evolution of general hospital care spreads, there is no suggestion that the private psychiatrists will cluster just in the metropolitan areas where they will do high-priced type of therapy. I think it must be recognized psychiatry is not all high-priced psychotherapy or highly individual psychotherapy but much wider than this. There is much evidence to show that as psychiatry can be dealt with as the rest of medicine for good or ill the psychiatrist will practise for good or ill as other members. This is not the holy couch or holy cow.

DR. GRAY: I may be wrong but I get the impression that the views of this Association in the method of compensating psychiatrists cannot have been made quite clear. This Association has not advocated any particular method of compensation such as fee-for-service.

THE CHAIRMAN: I quite understand that; they go along with the others.

DR. GRAY: On whatever basis the profession devises psychiatry will agree with it.

THE CHAIRMAN: Dr. Miller and gentlemen, we are very grateful to you for coming here. As you may well know the Commission is giving this matter of mental illness very special consideration; we have two studies being done for us by very competent men. We have one on the incidence of disease in Canada and a second by Dr. McKerracher, who is no doubt known to

you, on the matter of the changing patterns of treatment and evaluation that can be made on whether those new patterns are going to really produce results.

Dr. McKerracher has been to England to study the situation there and we are expecting much assistance from him. I know that he is relying on Associations such as yours for a great deal of help and if he has not been in touch with you already I am sure he will be.

We would appreciate all the co-operation possible from you in this field. Thank you very much.

DR. MILLER: Thank you, sir.

THE CHAIRMAN: We will adjourn now until 9.30 tomorrow morning.

--- Adjournment.

ROYAL COMMISSION ON HEALTH SERVICES

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ANGUS, STONEHOUSE & CO. LTD.
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ROYAL COMMISSION ON HEALTH SERVICES

Proceedings of the hearings held in Toronto, Ontario, on the 23rd day of May, 1962.

COMMISSION MEMBERS:

Chief Justice EMMETT M. HALL - Chairman

MISS ALICE GIRARD, R. N.

DR. C. L. STRACHAN

DR. ARTHUR F. VAN WART

MR. M. WALLACE McCUTCHEON, Q.C.

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DIRECTOR OF RESEARCH:

PROF. BERNARD BLISHEN

COMMISSION SECRETARY:

MR. N. LAFRANCE

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Dr. ARTHUR F. VAN WART

Mr. N. WALLACE McCUTCHEON, Q.C.

PROF. O.J. FIELDING

Dr. DAVID M. ROBITAIL

/ss

THE SECRETARY: The next submission is that of the Ontario Society for Crippled Children. It will be Exhibit 303, and Mr. Whaley will introduce his group and then speak on the brief.

S U B M I S S I O N O F

THE ONTARIO SOCIETY FOR CRIPPLED CHILDREN

---EXHIBIT NO. 303: Submission of the Ontario Society for Crippled Children.

APPEARANCES:

MR. L.P. WHALEY,
MR. R. AULD,
DR. I.W. DAVIDSON,
MR. C.D. DEVLIN,
MR. I. BAIN.

THE CHAIRMAN: Mr. Whaley.

MR. WHALEY: Mr. Chairman, lady and gentlemen, on my extreme right is Dr. Davidson our Medical Director; Mr. Auld, our Executive Director; immediately on my left is Mr. Ian Bain, Supervisor of Treatment Services and on my extreme left Mr. C.D. Devlin, a member of the Executive Committee of the Ontario Society and Chairman of the Committee who prepared the brief.

S U M M A R Y

The Ontario Society for Crippled Children welcomes the opportunity to participate in the enquiry being conducted by the Royal Commission on Health Services.

In this brief the services provided to physically handicapped children of Ontario by this Society are described. The main points in this brief are summarized below.

(1) The Ontario Society for Crippled Children directly and in co-operation with other public and private community organizations provides comprehensive rehabilitation services for approximately 15,000 physically handicapped children in Ontario.

(2) The Society's definition of a crippled child is a child under nineteen years of age whose musculo-skeletal activity is restricted for any reason. In practice, the Medical Advisory Committee is prepared to consider any physically handicapped child for service if a referring physician believes that the Society is able to provide appropriate treatment or other services for the child's particular condition and need.

(3) In order to co-ordinate the services for handicapped children and adults and prevent unnecessary gaps in services, the Ontario Society for Crippled Children has established with the Rehabilitation Foundation for the Disabled a Joint Action Committee which facilitates the transfer of patients from the Society to the Foundation at the age of nineteen years.

(4) While government financial assistance helped in the establishment of the Ontario Society forty years ago, government funds today constitute only 4% of the total revenue of the Society. At the present time 96% of the total budget of about $1,500,000 is received through voluntary public donation.

In this brief the services provided to physically handicapped children in Ontario by this Society are discussed. The main points in this brief are summarized below.

(1) The Society's Foster Care Program

Children are placed in foster homes by the Children's Aid Societies and in some instances by the public and private agencies. The Society's operations provide comprehensive homemaker services to children in Ontario.

(2) The Society's rehabilitation of a crippled child - a child who is mentally sound of age whose muscular skeletal activity is restricted for any reason. In practice, the Society's treatment facilities are prepared to consider any physically handicapped child for service if a reasonable prognosis indicates that the Society is able to provide appropriate treatment or other services for the child's specific condition and need.

(3) In order to co-ordinate the services for handicapped children and adults and prevent unnecessary gaps in services, the Ontario Society for Crippled Children has established with the Ontario Government Committee for the Rehabilitation Joint Action Committee which facilitates the transfer of children from the Society to the Foundation at the age of 16 years.

(4) The government financial assistance based in the establishment of the Ontario Society forty years ago, continues today constituting only 4% of the total revenue of the Society. At the present time 98% of the total budget of about $1,300,000 is received through voluntary public support.

(5) The Ontario Society believes that the record of its service to many thousands of crippled children over the past forty years and the confidence and support which the public continues to invest in the Society are testimonials to the essential role that voluntary health agencies can and do play in the community. The Society, however, does not believe that voluntary agencies alone can or should meet all the needs of any group of the general population.

The Ontario Society for Crippled Children believes its efforts must be complementary to governmental health and welfare programs based on a foundation of sound legislation, dynamic administration and financial participation by government geared to the changing needs of a growing population of physically handicapped children.

That, sir and Members, is our summary.

THE CHAIRMAN: Thank you very much, Mr. Whaley. Are there some aspects of the summary or the brief itself that you would like to expand upon now?

MR. WHALEY: Not at the present moment, sir.

THE CHAIRMAN: In Paragraph 1 of your summary you say your organization provides rehabilitation services for approximately 15,000 physically handicapped children. Have you an estimate of the number of physically handicapped children in Ontario?

MR. WHALEY: Mr. Auld will answer that, sir.

MR. AULD: Mr. Chairman, it is rather

(5) The Urban Society believes that the record of its service to many thousands of crippled children over the past twenty years and the confidence and support which the public continues to invest in the Society are the results of a essential role that voluntary agencies can and do play in the community. The Society, however, does not believe that voluntary agencies alone can or should meet all the needs of any group of the general population.

The Urban Society for Crippled Children believes an effective must be complementary to governmental health and welfare programs based on a foundation of sound legislation, which authorization and financial assistance by government, geared to the changing needs of a growing population of physically handicapped children.

That, sir and members, is our summary.

MR. CHAIRMAN: Thank you very much, Mr. Hardy. Do any of the same members of the Library or the Legislature want you would like to ask questions of Mr. Hardy: Not on the presentation, Mr. Hardy?

MR. [illegible]: Mr. Chairman, I'd just [illegible] for my own information, provide or rehabilitation equal to the [illegible] in [illegible] supervised [illegible], have you an estimate of the number of physically handicapped children in Ontario?

MR. HARDY: Mr. Chairman, I'm not really aware that, [illegible]

MR. [illegible]: Mr. Chairman, it is rather

difficult to either estimate or have an accurate count of the number of children because, unfortunately, the Society does not have the means whereby we can record all of the physically handicapped in the Province. We have made an attempt through our surveys and our local community resources to establish all the needy crippled children in the Province, and on this basis we have to date found and are looking after 15,000. We would hope that some means would be found whereby somebody with the proper authority ...

THE CHAIRMAN: Some registry, but that hasn't been developed as yet.

MR. AULD: No, sir, not in this Province.

THE CHAIRMAN: How have you found 15,000? This is a very substantial figure.

MR. AULD: Well, we have fortunately, sir, a long record based on the fact that we are associated with 226 service clubs situated in all the communities right across the Province and they, in fact, are our local agents and in cooperation with the clubs and our field service composed of 27 public health nurses we find these cases either on the basis of direct surveys where we ask the community to refer all known cases to central sources or by virtue of the public relations campaign conducted by service clubs and the Society . Interested citizens or parents refer these children to us for assistance and, of course, naturally we get many of our cases through the medical profession itself, the family physician.

difficult [illegible] estimate to have an accurate count of the number of children diseased, unfortunately, the locality does [illegible] we can record all of the [illegible] in the province. We have made an attempt [illegible] surveys on the local community [illegible] all the ready crippled children [illegible], and on this basis we have to date found and [illegible] 1,000. We would hope that some [illegible] found whereby some body with the proper authority ...

[illegible]: [illegible] legality, but that hasn't been developed as yet.

[illegible]: No, sir, not in this [illegible]

[illegible]: How have you found [illegible] This is a very [illegible] figure.

[illegible]: Well, we have fortunately, sir, a long record here on the [illegible] associated with [illegible] children in all the communities right across the province, in fact, are our local [illegible] in cooperation with the clubs and our [illegible] service consisting of 22 public health nurses. We find these cases either on the basis of survey [illegible] the community to [illegible] cases to central [illegible] or by the [illegible] relations [illegible] through by service clubs and the [illegible]. Interested citizens [illegible] children to us for assistance and, of course, [illegible] we get many of our cases through the medical profession, [illegible] family [illegible].

THE CHAIRMAN: Once the case becomes known, what is the procedure then?

MR. AULD: It could vary, sir, depending on the circumstances, but generally, for example, if an interested neighbour refers the child we contact his family physician and we deal with him to determine what he feels is required for that particular patient and if we have the facilities that are available for that child and he okays it, we then proceed to carry out the required treatment.

THE CHAIRMAN: Just what do you mean by carry out? It is surgical treatment of some kind, I take it, it may or may not be, but it involves this child and some form of rehabilitation service.

MR. AULD: Perhaps Dr. Davidson, our Medical Director, would like to answer this question.

DR. DAVIDSON: Mr. Chairman, it may be any type of medical treatment, medical or surgical, or it may be one of the other services that the Society provides for crippled children quite apart from medical or surgical care. Our concern is to see that the child gets these services that are provided by the medical profession in those cases where the family has not been able to find the means to provide them. In other words, we will assist them in getting the proper medical and surgical care. It may be that the family physician may like to refer that child to the Hospital for Sick Children for a particular treatment. Our district nurse will see to it that transportation is arranged for that child to get to the hospital or a centre, wherever

[illegible]

[illegible] could vary, sir, depend-
[illegible] on the circumstances, but generally, for example,
if an interesting patient [illegible] sees the only one contact
his family physician [illegible] within him to determine
what to [illegible] for that particular patient and
if he has the [illegible] that are available for that
child and he knows it, he then proceed to carry out the
required treatment.

[illegible] Thank you, Dr. [illegible] for
an excellent [illegible] This educational treatment of some kind,
I take it, it may or may not be, but is a worthwhile trip
[illegible] of children [illegible] ideas.

[illegible] Dr. Jacobson, our
[illegible] section, would like to answer this question.

Dr. Jacobson: Mr. Chairman, it may
be any type of [illegible] treatment, medical or surgical, or
it may be one of [illegible] to evidence that the society
provides [illegible] children quite a lot from medical
or surgical [illegible] to see that the
child gets these [illegible] that are provided by the medical
profession in [illegible] the family has not been
able to find the means to provide them. In [illegible] cases,
we will assist [illegible] getting the proper medical and
surgical care. It [illegible] the family [illegible]
the [illegible] to [illegible]
[illegible] for a [illegible] treatment. [illegible]
more will [illegible] that [illegible]
for that child to get the medical or surgical, [illegible]

the treatment is to be provided. If it is a question of purely rehabilitation service or at the local treatment centre, there again there are charges to be met and if the family are unable to provide and pay for these services, then the Society will see to it that the services are paid for on a fee for service basis according to whatever the tariff is in the local centre. We actually buy services for the child and transportation to areas in which they can get the particular service which may or may not be provided free for that particular patient.

MR. AULD: We have another method, sir, of determining the program. The Society conducts many diagnostic clinics right across the Province in which we send out clinical teams from the various teaching centres to the communities which we feel require this service. All the known children are brought to that clinic where they are examined by the specialist and a program is advised at that time. If it requires surgery then, of course, the child with the concurrence of the family physician is referred to the hospital that may carry out this procedure. If it requires some other form of treatment such as physio or occupational therapy, there again the case is referred with the approval of the family physician.

THE CHAIRMAN: We have been talking about the idea of a prepaid health service program. Do you see the work that you are doing being adopted into such a program, or is it something that will have to continue regardless of whatever developments for the future may be?

the tree that is to be provided. If it is a question of partial rehabilitation service on at the local treatment centre, there again these are charges to be met and if the family are unable to provide and pay for these services, then the society will see to it that the services are not withdrawn. So for service based according to need the tariff is in the local centre. We actually have services for the child and transportation to areas in which they can get the particular service which they or may not be providing free for that particular

4. A fifth we have another method, sir, of determining the program. The society conducts many community clinics, right across the province in which we carry out a clinical team from the various treating centres to the communities with we feel requires this service. All the known children are brought to that clinic where they are examined by the specialist and a program is advised at that time. If it requires surgery then, of course, the child with the consultant or locally practitioner is referred to the hospital that can carry out this operation. It is sometimes some other form of treatment which is provided by occupational therapy there again can be provided with the approval of the family physician.

Mr. Mitchell: Mr. Speaker, a little about the loss of a provincial partial service program. I do you see the point that we are losing some of the local program, or is it necessary, that will mean to continue improvement of children developed in the intake area.

MR. AULD: Sir, we haven't considered specifically that question, but I could quote an example which may typify the situation. Before the advent of the Hospital Plan the Society was involved in quite a bit of the payments of hospital bills. When this came along the release of these funds allowed ...

THE CHAIRMAN: The release of the funds that you used to pay the hospitals?

MR. AULD: That is right, sir, allowed us to move into other fields. As an example, it is a partial example, this allowed the Society to start its more active planning and production of our new crippled children's treatment centre on a Provincial basis. Then we feel that the voluntary agencies are most important working hand in hand with Government. It can move forward and provide the extra and needed service over and beyond standard things which are available to the general public.

THE CHAIRMAN: You spoke of the treatment centre, that is a new institution that was offically opened since we have been sitting here as I recall from newspaper articles. Was that provided by the Provincial Government, the building, how did it come about?

DR. DAVIDSON: Mr. Chairman, the Ontario Crippled Children's Centre is a public hospital within the terms of the Act and comes within the regulations set down under the Ontario Hospital Services Commission. It was conceived by the Ontario Society for Crippled Children. They appointed a campaign committee

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Mr. ADAMS: Sir, we haven't considered specifically that question, but I could quote an example which has to do with education. Before the advent of the Medicare Plan, our society was involved in quite a lot of the payments of hospital bills. When that was taken over, we release - these funds allowed ...

Mr. CHIKMAN: The release of the funds that you were to pay the hospitals?

Mr. ADAMS: Yes, to come into other fields. As an example, it is a partial answer, this allowed the society to start its more active planning and production of our new expanded programs. I think that the voluntary agencies are most important working part of our work with Government. It our move towards the provision of the extra and needed service over and beyond government funds which are available to the general public.

Mr. CHIKMAN: You spoke of the treatment centre, that is a new institution that was officially opened since we have been sitting here as I recall, from correspondence notes. Was that provided by the Provincial Government, the building, how did it come about?

Mr. CHIKMAN: Mr. Chairman, the Metro St. Joseph Children's Centre is a public hospital within the meaning of the Act and comes within the regulation set down under the Metro Hospital Board's jurisdiction. It was approved by the Metro Hospital Board, on Original Allocation. They constructed a campaign committee

that raised the necessary funds to build that as one does in a hospital anywhere in the Province and received the usual Federal and Provincial grants according to the number of beds and out-patient space and so on that was available. Therefore, the money and the planning of it, the money was raised by a special campaign under the direction of the Ontario Society for Crippled Children, and the Ontario Society for Crippled Children has a very specific interest in this centre, in that many of the services which are provided on day basis, on an out-patient basis which are not presently covered under the Ontario Hospital Services Plan are purchased, in fact, by the Society for the children whose parents are unable to pay for this service.

THE CHAIRMAN: How many children can the treatment centre accommodate as in-patients?

DR. DAVIDSON: We have 105 beds at the moment, sir, and we have accommodation facilities for treating up to 300 on day care basis, out-patient program.

THE CHAIRMAN: I know you haven't been able to do this on a Province-wide basis, but in a smaller area, say the area of Metropolitan Toronto, are you able to forecast in any way what the incidence of this -- it isn't a disease -- off this conditon may be expected to be so as to be able to plan for the future?

DR. DAVIDSON: Well, Mr. Chairman, to give some direction as to the size of our building, the out-patient or day care program as we call it, was making provision of services for those children suffering

[illegible] 1969

[illegible] Lawrence Lane is [illegible] that as one
goes in a [illegible] are in the [illegible] and received
the usual [illegible] ratios according to the
number of [illegible] space and to [illegible]
[illegible] and the [illegible]
of it, the [illegible]. Especial emphasis
under [illegible] of the Atlantic Seaboard [illegible]
[illegible], and the [illegible] for [illegible] children
has a very [illegible] in this centre, i.e. [illegible]
[illegible] provided on day basis,
on an out-patient basis which are not [illegible] covered
under the [illegible] basis [illegible] are [illegible]
in fact, by [illegible] for [illegible] children whose parents
are [illegible] this [illegible].

[illegible] How many children can
the [illegible] accommodate at [illegible]?

[illegible] We have 180 [illegible] at the
moment, [illegible] additions [illegible]
[illegible] [illegible] [illegible] [illegible]

[illegible] How [illegible]
been [illegible] [illegible] [illegible], but [illegible]
[illegible], [illegible] [illegible], are
[illegible] [illegible] [illegible] the incidence of
this -- [illegible] -- [illegible] this condition [illegible]
[illegible] [illegible] [illegible] [illegible] [illegible]

[illegible] [illegible] [illegible] [illegible] [illegible],
the [illegible] [illegible] [illegible] [illegible] [illegible],
[illegible] [illegible] [illegible] [illegible] [illegible] [illegible]

from disability as a result of cerebral palsy in the City of Toronto at that time and surrounding Metro area.

THE CHAIRMAN: 2,000,000 population.

DR. DAVIDSON: Yes, in the Metro area, there were two centres in existence providing a day care program. One was the Junior League, the Cerebral Palsy Treatment Centre Clinic and the other was the St. Paul's Cerebral Palsy Treatment Centre, and these two units were providing care for approximately 75 children up to nineteen years of age. In our planning these two units were to be absorbed into the program of the Ontario Crippled Children's Centre; it was felt as far as the cerebral palsy group of children were concerned that this might certainly be enlarged with added facilities. We have only been in operation a matter of a few months and we are roughly running about one-third more than that, just under 100, so at the moment we haven't refused any applications from Metropolitan Toronto.

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[illegible] disability as a result of prenatal delay in the [illegible]
[illegible]ity of Toronto at that time and surrounding Metro
[illegible]

[illegible] 2,000,000 population,
[illegible] Yes, in the Metro area,
there are two centres in [illegible] providing a day care
program, [illegible] in Junior Jardin, the Gerstral
Talon [illegible] Clinic. In the other was the
St. Paul's [illegible] Day Nursery Centre, and there
was [illegible] for approximately 75
children up to nineteen years of age. In our planning
there is two units [illegible] a nursery into the program
of the [illegible] children's home ; it was felt
as large the [illegible] day group of children were
concerned [illegible] would be encouraged with
[illegible] facilities. We were [illegible] in operation a
matter of [illegible] are roughly running about
one-third [illegible] ; just under 150, so at the
moment [illegible] based [illegible] from [illegible]

It is our hope, of course, that our day care program will involve all children with crippling conditions that come within our definition, and it was on that basis of 100, and a very rough figure is that approximately 30% of our crippled children that we take care of suffered from cerebral palsy when our estimate of 300 was made on an out-patient basis, and we felt that this would be sufficient for our needs in metropolitan Toronto for a period of time.

THE CHAIRMAN: Well then, with an overall population of 6 million-plus for the province, assuming pretty well the same incidence for the province, what about the other parts of the province? Are they being served?

MR. AULD: The Society, in 1948, started the first residential cerebral palsy centre just outside of London, more or less as a pilot plan, because there was not too much interest in this particular aspect at that time, and because we were only able to operate 8 months a year. We sent out the professional staff to most of the major communities in the province, and they examined and assessed all of the cerebral palsied children in these particular areas, and as a result of this impetus there have been quite a number of local treatment centres established, with the support, and in many cases, the active support today of our various clubs and societies.

So, to date, we now have 22 of these centres, spread across the province, which are connected in some form or another with the Society, and they look

It is our hope, of course, that our day care program will involve all children with orthopedic conditions that come within our definition, and it was on that basis of 100, and a very rough figure is that approximately 30% of our crippled children that we take care of suffered from cerebral palsy when our estimate of 300 was made on an out-patient basis, and we felt that this would be sufficient for our needs in metropolitan Toronto for a period of time.

THE CHAIRMAN: Well then, with an overall population of 6 million-plus for the province, assuming pretty well the same incidence for the province, what about the other parts of the province? Are they being served?

MR. AULD: The Society, in 1948, created the first residential cerebral palsy centre just outside of London, more or less as a pilot plan, because there was not too much interest in this partitular aspect at that time, and because we were only able to operate 3 months a year. We sent out the professional staff to most of the major communities in the province, and they examined and assessed all of the cerebral palsied children in these particular areas, and as a result of this impetus there have been quite a number of local treatment centres established, with the support, and in many cases, the active support today of our various clubs and societies.

So, to-day, we now have 12 of these centres, scattered across the province, which are connected in some fashion or other with the Society, and they look

after, within their means, the local situation, and the new centre was conceived with the idea of providing a focal point for those children that were unable to attend these local resources.

So that the new centre does not, in any way, supplant the local services that are going on across the province. It is supplementary and complementary to the overall, broad program that we envisage right across the whole province, so that we, in every way, try to maintain and encourage local services, and the Society is in back of that, to stand by and provide and fill in those needs that are beyond the resources or capabilities of any particular community.

THE CHAIRMAN: Well, do you foresee that some time in the future, either in a year or a little more distant, that there will have to be additional treatment centres at some other parts of the province, either in the south-west or the north-east, something like that?

MR. AULD: Mr. Bain, who is particularly acquainted with this subject, perhaps would like to answer that question, sir.

MR. BAIN: Mr. Chairman, it is difficult to know at any time what the need might be in any particular community. The Society has, on occasion, been asked by various communities to examine their local needs for treatment, because in many cases the treatment centre in a community will serve a fringe area outside the community itself, and this involves problems of transportation, generally done by volunteers,

action, with its thirty-year, the local situation, and the new concepts were involved with the idea of providing a focal point for those activities that were unable to attend the local meetings.

In that the new centre does not, in any way, replace the local services that are being on-going the provinces. It is supplementary and complementary to the events. A broad program that we envisage might assure the whole province, so that we, in every way, try to maintain and encourage local services, and the foolish in up back of that, to stand by and provide and fill in those needs that are beyond the resources or capabilities of any particular community.

MR. CHAIRMAN: Well, do you foresee that some time in the future, either in a year or a little more distant, that there will have to be additional treatment centres at some other parts of the province, with a in the north-west or the north-east, something like that?

Mr. A. G.: Mr. Chairman, who is particularly associated with this auditor, perhaps would like to answer that question, sir.

[illegible] to know at any time what the real worth be in any particular community. The [illegible], on [illegible], been called by various communities to assess their real needs for treatment, because in many cases the treatment centre in a community will serve a fairly area outside the community itself, and this involve particular of transportation, especially done by volunteers,

and as a result of this, other smaller communities have asked us, is there a need in our area for a treatment centre, and is it possible for us to have it, and on the basis of this we will go into that centre, examine their apparent needs, based on the records the nurse has on that area, and also the ability to raise the funds and provide the staff.

With that information we are able to advise the community whether in our view it is feasible for them to have a local community treatment centre.

It would be difficult, I think, for us to visualize at the moment any particular area which appears to be in need of a treatment centre and able to provide one.

THE CHAIRMAN: I perhaps didn't make myself plain. I am not talking about today. In a forecast population growth, a forecast from the incidence of cerebral palsy, what do you foresee as going to be the needs for Ontario, say, in the next 20 years, or have you been able to give any thought, any real thought, to what the needs are going to be by 1980 or 1990, because we are looking forward now to at least that time period?

MR. AULD: I would say, sir, that we now have centres in the major centres in the province, but some of these smaller communities are rapidly expanding, and we already have inquiries from them, so I would say that within a reasonable length of time certainly there is going to be demand and a need to increase the treatment centre facilities across the

and as a result of this, other smaller communities have asked us, is there a need in our area for a treatment centre, and is it possible for us to have it, and on the basis of this we will go into that centre, exactly as their management is, based on the records the nurse has on that area, and also the ability to raise the money and provide the staff.

With that information we are able to advise the community whether in our view it is feasible for them to have a local community treatment centre.

It would be difficult, I think, for us to visualize at the moment any particular area which appears to be in need of a treatment centre and able to provide one.

MR. [illegible]: I perhaps didn't make myself plain. I am not talking about today. In a forecast population growth, a forecast from the incidence of cerebral palsy, what do you foresee as being to be the needs for instance, say, in the next 20 years, or have you been able to make any thought, any real thought, to what the needs are going to be by 1980 or 1990, assuming we are looking forward now to at least that time period?

MR. [illegible]: I would say, sir, that we now have centres in the major centres in the province, but some of these smaller communities are heavily subsidized, and we already have requisitions from them, so I would say that within a reasonable length of time certainly there is going to be demand and a need to increase the treatment centre facilities across the

province, and taking almost a guess, sir, I would say that, based on the length of time you suggested, probably there would be a 50% increase in the number of centres across the province.

THE CHAIRMAN: Now then, we come to your Recommendations 4 and 5, where you speak of the present financing, 4% from government funds and 96% from voluntary public donation, and you go on to say:

"The Society does not believe that voluntary agencies alone can or should meet all the needs of any group."

By "any group" you mean the crippled children group here? Would you expand on that, and tell us what you think will be the development and the needs in this next 15 to 20 or 25-year period?

MR. AULD: Well, sir, when we refer to the Society only receiving 4% of its total revenue from governmental sources, this does not take into account the fact that the treatment centres across the province receive federal health grants.

THE CHAIRMAN: You told us that the children in the centre are paid for as ordinary patients?

MR. AULD: No, sir. This is the only centre that is classed as a hospital. The other 21 centres are classed as straight treatment centres, and are in receipt of money from the federal health grants to the extent, I believe, of 141,000 dollars.

Those centres are, as I recall it,

provinces, and that is almost a crisis, sir, I would say that, based on the length of time you suggested, probably there would be a 5% increase in the number of centres across the province.

MR. CHAIRMAN: Now then, we come to your recommendation 4 and 5, where you speak of the present situation, of from government funds and 98% from voluntary public donation, and you go on to say:

"The society does not believe that voluntary societies alone can or should cost all the needs of any

Do "any" and "cost" you mean the crippled children [illegible]? Would you expand on that, and tell us what you think will be the development and the needs in this next 10 or 20 or 25-year period?

MRS. HULL: Well, sir, when we refer to the society only receiving 4% of its total revenue from government sources, this does not take into account the fact that the treatment centres across the province receive federal subsidy.

MR. CHAIRMAN: You told us that the [illegible] in the centre are paid for as ordinary salaries.

MRS. HULL: No, sir. That is the only centre that is closed as a hospital. The other 24 centres are classed as out-patient treatment centres, and are in receipt of money from the general health operate [illegible]

These centres are, as I mentioned it,

spending between half-a-million and three-quarters of a million on their overall programs, therefore again, the small portion is coming from governmental sources.

I would say, sir, if the full impact of the federal health grants was brought into play, these centres certainly could expand and develop their services where they would be truly comprehensive within their community, and enable them to carry out a full program for their children.

Now, if the population keeps increasing the way it is and we keep expanding, I would say that within maybe a 5 or 10-year period, that probably this money would have to be doubled in terms of their total expenditures, so perhaps we are talking in terms of a million-and-a-half dollars for these treatment centres, and we would hope that the federal health grants, or whatever source it is coming from, would be in proportion to that.

THE CHAIRMAN: Then what about the operations of the Ontario Society for Crippled Children, where you have a budget of 1,500,000?

MR. AULD: Well, based, sir, on past experience, our budget has gone up fairly rapidly in the last 10 years, and our caseload has more than doubled in the last 10 years, so again, we must assume on that basis, if the present rate holds, that our budget and our caseload would be doubled again in a 10-year period.

THE CHAIRMAN: Do you anticipate that you will be able to carry on in the future as you have

operating between half-a-million and three-quarters of a million on their overall programme, therefore again, the small portion to come from government sources.

I would say, sir, if the full impact of the federal health grants was brought into play, there cannot be anybody could argue and develop their services where they would be truly comprehensive within their community, and enable them to carry out a full programme for their children.

Now, if the population keeps increasing since the way it is and be been expansion, I would say that within maybe two or 10-year period, that probably this money would have to be doubled in terms of their total expenditure, so perhaps we are talking in terms of a million-and-a-half dollars for these treatment centres, and we would come from the federal health grants, or whatever source it is coming from, would be in proportion to that.

The chairman: I keep worrying about the operation of the Pediatric Institute for Retarded Children, where you have a budget of [illegible].

Mr. Mills: Well, round, sir, on past experience, our budget has gone up fairly rapidly in the last 10 years, and our expenditure has more than tripled in the last 10 years, so as it, is very dangerous at that basis, if the present rate holds, that our budget and our expenditure would be multiplied again from [illegible] period.

The chairman: Do you anticipate that you will be able to carry on in the future as you have

done in the past, principally, or almost entirely, through public donation?

MR. AULD: I am afraid that is a rather difficult question to answer, sir. It depends on public support, which we have certainly enjoyed in the past. With our type of fund-raising campaign, which is a direct mail campaign, there is no pressure on the public whatsoever to contribute to the Society, therefore, based on experiences elsewhere on direct mail campaigns, I would say that on the basis of the present population, that we are getting pretty close to the limit of what we can expect.

As a matter of fact, our record is most outstanding on the continent in terms of a direct mail campaign, so I can see where we are reaching a limit until the population takes a rapid jump, so certainly we would hope to have, or expect, a rather better and closer partnership with the governmental sources.

COMMISSIONER FIRESTONE: Mr. Whaley, you are speaking of approximately servicing 15,000 physically handicapped children in Ontario, and I understood from you that these are needy 15,000 handicapped children. Could you define for us what you mean by needy?

DR. DAVIDSON: Mr. Chairman, to Mr. Firestone's question, our definition of need is that the child is in need of this particular service at this particular time. It does not necessarily mean that the family, the parents, are on a municipality's

indigent list, but it does mean that the family at that particular time and their particular circumstances are not apparently able to provide that service.

In many cases, these families, as circumstances change a little later on, attempt, in some way, to repay part of what has been provided; not always, but in most cases we have -- but in all cases, first of all, we have a means of assessing the apparent ability to pay. That is gone into very carefully by, first of all, our District Nursing Office and also by the members of the Crippled Children's Committee of the local Easter Seal Club, which is our Society in that particular community, and they investigate the ability to pay and what the family's circumstances are at that particular time.

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It may well be that the father is making $60.00 a week and he has got five or six other children and maybe certain other demands; he is mortgaged heavily, he has a lot of payments to finance companies, and he has a brace that is to cost $275.00 and at that particular time the father hasn't got $275.00, nor can he see in the immediate future to provide that brace. To us that child is needy.

COMMISSIONER FIRESTONE: Has your Ontario Association established a means which the administrative officers or nurse, whoever does the investigation, uses in order to decide need not?

MR. AULD: Based on an individual basis. It is left largely to the discretion of the nurse working in co-operation with the local service club, Easter Seal Service Club, and they base it entirely on the circumstances of the family. So that even if a man may be having a relatively good income, if there are circumstances whereby he is financially embarrassed, despite the fact that on the surface he is well able to pay this, if this equipment or treatment is going to affect the balance of the family, then we feel we nave a responsibility and duty to assist this family.

COMMISSIONER FIRESTONE: If, for example, the investigating officer concludes that the family can afford to pay part of the cost of the expenses, do you have an arrangement whereby you assess part of the cost?

MR. AULD: It is not actually an

It may well be that the father is making $40.00 a week and he has got five or six other children and quite certain expenses; he is mortgaged heavily, he has a lot of payments to finance companies, and he has a bill that is to cost $275.00 and at that particular time he haven't got $275.00, nor could he see in the immediate future to provide that house. To us that could be needy.

MR. CHAIRMAN: His wife Ontario Association established a rules which the administrative officers or nurse, whoever does the investigation, have in order to decide need.

MR. ADAM: Based on an individual basis. It is left large to the discretion of the nurse working in conjunction with the local service club, Ontario Legal Service Club, and they base it entirely on the circumstances of the family. So that even if a man may be having a relatively good income, if there are circumstances whereby he is financially embarrassed, despite the fact that on the surface he is well able to pay this, if this enrichment or treatment is going to affect the balance of the family, then we feel we have a responsibility and duty to assist this family.

CONTROLLER FLEMMING: If, for example, the investigation officer concludes that the family can afford to pay part of the cost of the treatment, would he be in a disagreement whereby you absorb part of the cost.

MR. ADAM: It is not again by an

assessment. Say they can afford $10.00 a week towards a treatment service program or $20.00 towards a pair of braces, we ask them if they can pay this. It is if they can pay this.

COMMISSIONER FIRESTONE: In other words, you use your judgment in the various cases?

MR. AULD: Yes.

COMMISSIONER FIRESTONE: What happens if a family who is in an income position who can afford to pay for this service but they like this rehabilitation service you provide to children and they come to you and ask you: "Will you take my child in? We will pay for the service."

MR. AULD: We have a number of instances of that.

COMMISSIONER FIRESTONE: You would accept the child?

MR. AULD: Yes.

COMMISSIONER FIRESTONE: If it is physically handicapped?

MR. AULD: Yes.

COMMISSIONER FIRESTONE: May I now come to paragraph 75 on page 17, sir? You say:

"Much remains to be done in the "co-ordination of services for the "handicapped, among private health "agencies themselves, and between "voluntary agencies and government "as a whole."

Mr. Whaley, what is the relationship between government and voluntary efforts? How do these

assessment. Say they can afford $10.00 a week towards a treatment service program or $20.00 towards a pair of braces, we ask them if they can pay this. It is if they can pay this.

COMMISSIONER FRASER: In other words, you use your judgment in the various cases?

Mr. AULD: Yes.

If a family who is in an income position who can afford to pay for this service but they like this rehabilitation service you provide to children and they come to you and ask you: "Will you take my child in? We will pay for the service."

Mr. AULD: We have a number of instances of that.

COMMISSIONER FRASER: Do you accept the child?

Mr. AULD: Yes.

COMMISSIONER FRASER: If it is physically handicapped?

Mr. AULD: Yes.

COMMISSIONER FRASER: May I now come to paragraph 75 on page 17, sir? You say:

"The problems to be done in the "co-ordination of services for the "agencies themselves, and between "voluntary agencies and government "as a whole."

Mr. Wheley, what is the relationship between government and voluntary effort? How do these

two groups dovetail their operations in this particular field?

MR. WHALEY: Mr. Auld will answer.

MR. AULD: Mr. Chairman, the Society has no formal relationship with either the provincial or federal government, but we do work very closely with the various departments, both federally and provincially and we are in constant contact with the responsible officers. Also members of the Society are on various advisory groups to the government; for example, the new Vocational and Rehabilitation Act which is coming into this province, we have a member of our Society sitting on the advisory committee to the Minister of Welfare. We are also in constant touch with the Health Department, and in the case of any problems in relation to either a specific case or generally, we know who to deal with and attempt to find a satisfactory answer as applied to that particular case.

By the same token, at the federal level, in terms of getting interpretations of the various acts and orders-in-council which make available certain monies for this kind of work, again we are able to call directly to the responsible party and ask for the interpretation.

COMMISSIONER FIRESTONE: Mr. Auld, this paragraph, 75, suggests that much remains to be done in co-ordination between voluntary agencies and the government as a whole. Can you suggest some specific areas where increased co-ordination and co-operation can be achieved?

[illegible] wants [illegible] their operations in this particular [illegible]

[illegible]. WHITBY: Mr. Auld will answer.

MR. AULD: Mr. Chairman, the Society has no formal relationship with either the provincial or federal government, but we do work very closely with the various departments, both federally and provincially and we are in constant contact with the responsible officers. Also members of the Society are on various advisory groups to the government; for example, the new Vocational and Rehabilitation Act which is coming into this province, we have a member of our Society sitting on the advisory committee to the Minister of Welfare. We are also in constant touch with the Health Department, and in the case of any problems in addition to either a specific case or generally, we have gone to them with and attempt to find a satisfactory answer as applied to that particular case.

By the same token, at the federal level, we [illegible] getting interpretations of the various acts and [illegible]-in-council which make available certain [illegible] we are able to [illegible] to the [illegible] Society and ask for the [illegible].

[illegible]: Mr. Auld, this paragraph, 7b, suggests that you seem to be done in co-ordination between [illegible] agencies on the [illegible]. Can you suggest any [illegible] areas where increased co-ordination and co-operation can be achieved?

MR. AULD: I would like to suggest, sir, if there was some way whereby we could be less departmentalized than we are now which would enable us to move forward on a total program for the individual child. For example, there are federal health grants regulated by an order-in-council through the health and welfare department in Ottawa, and then we move over to the Department of Labour who is administering the new Vocational and Rehabilitation Act. In practice all these things dovetail in terms of working out and formulating a program for a child or young adult. But you have to step over a wall in effect to bring this whole thing into effect and practice in the field.

And the same thing applies at the provincial level where again it is broken down into health, welfare and education. We would hope, sir, that both at the federal and provincial level all these aspects of a rehabiltation program can be brought under one central force so that there would be a flow whenever the child becomes crippled until finally a solution is found for that particular person.

COMMISSIONER FIRESTONE: In principle this is a very appealing suggestion, but I am just trying to visualize how this would work in practice. You say you wish to have federal government contributions less departmentalized. At the provincial level would you like to see a transfer of vocational functions transferred to the Welfare Department, Labour Department?

MR. AULD: I don't know what the eventual solution would be. But, as an example, we are

MR. [illegible]: I would like to suggest, sir, if there was some way whereby we could be less departmentalized that we are now which would enable us to move forward on a total program for the individual child. For example, there are federal health grants earmarked for [illegible] through the health and welfare department in Ottawa, and then we move over to the department of labour who is administering the new education and rehabilitation act. In practice all these things dovetail, in terms of working out and formulating a program for a child or young adult, but you have to step over a wall in effect to bring this whole thing into effect and practice in the field.

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COMMISSIONER STRUTT: In principle this is a very appealing suggestion, but I am just trying to visualize how this would work in practice. You say you wish to have federal government coordination less departmentalized. At the provincial level would you like to see a transfer of rehabilitation transferred to the [illegible] department, labour department?

MR. ADAMS: I don't know what the eventual [illegible] would be. But, if in exchange, we are

attempting in the voluntary field to bring this co-ordination about, and on the federal level the Canadian Council for Crippled Children and Adults, of which we are a member, is working with the Polio Foundation, that is nationally, and they will be coming about very shortly. The Canadian Rehabilitation Council is going to draw together the various organizations concerned with rehabilitation where they can sit down and formulate an overall program for the handicapped persons, and I would hope that a similar pattern could be developed at the government level so you would have inter-departmental committees which would deal with these matters.

COMMISSIONER FIRESTONE: If I understand you correctly, sir, then, this co-ordinating function as you visualize would be achieved at the planning level rather than on the operating level; is that correct?

MR. AULD: That is right, sir.

COMMISSIONER FIRESTONE: Because this could be achieved through a health planning agency in this particular field to which various departments might send representatives to you. Or it could be achieved through the effort of private organizations and public organizations. But this would be co-ordination at the planning level as distinct from the operating level.

MR. AULD: Correct, sir.

COMMISSIONER FIRESTONE: You would want to have the administration of the Rehabilitation Act handled by the health departments, each department would

attempting in the voluntary field to bring this co-ordination about, and on the federal level the Canadian Council for Crippled Children and Adults, of which we are a member, is working with the Rehabilitation Foundation, that is nationally, and they will be coming about very shortly. The Canadian Rehabilitation Council is going to draw together the various organizations concerned with rehabilitation where they can sit down and formulate an overall program for the handicapped persons, and I would hope that a similar pattern could be developed at the government level so you would have inter-departmental committees which would deal with these matters.

MR. MISSENDEN FURTHERMORE: If I understand you correctly, sir, then, this co-ordinating function as you visualize would be achieved at the planning level rather than on the operating level; is that

W. ALLEN: That is right, sir.

could be a level through a really planning agency in this particular field so that various departments might send representatives to you. Or it could be achieved through the development of private organizations and public organizations. But this would be co-ordination at the planning level as distinct from the operating level.

W. ALLEN: Correct, sir.

MR. MISSENDEN FURTHERMORE: You would want to have the administration of the rehabilitation as handled by the one or two departments, with government now

look after its own affairs but they would co-ordinate planning; is that correct?

MR. AULD: That is correct, sir.

COMMISSIONER FIRESTONE: You say:

"In cc-operation with all branches of "government and with other voluntary "organizations ....."

Can you elaborate?

MR. AULD: I was referring to the federal level, but it is also going to the provincial level. As a matter of fact, the Society already has an agreement with the provincial branch of the Polio Foundation. Not too many years ago we were in effect developing our services, and by getting together and by formalizing a co-ordinating committee we have now evolved whereby the Society is responsible for crippled children up to 19 years of age and then the Polio Foundation takes over, and our field staff and administrative staff and board level are working to ensure that there is a smooth flow for the patient, so in many cases the patient doesn't realize he has changed from one department to another; the program still carries on.

COMMISSIONER FIRESTONE: It has been suggested to us that Canada should set up a national health planning agency. If that agency were set up, and that agency would comprise representatives from private as well as public organizations and the professions, do you think it would include a section dealing with the crippled child and the handicapped adult?

MR. AULD: The two programs are quite similar, but in the application of those programs there are quite a number of differences. Therefore I would certainly hope that even though the two of them would be considered together there would be some difference so that the needs of the crippled child versus the needs of the crippled adult would be taken into account.

COMMISSIONER FIRESTONE: Thank you very much, sir.

COMMISSIONER STRACHAN: Mr. Chairman, gentlemen, I note in paragraph 8 that cleft lip and/or cleft palate are included in your definition of crippled child. I note that you have had 1,237 such cases with 179 new cases last year. Where are these children treated and is the new treatment centre equipped and staffed to handle these cases?

MR. WHALEY: Dr. Davidson will answer that, Mr. Chairman.

DR. DAVIDSON: Mr. Chairman, in answer to Commission Strachan's question, in answer to the cleft lip and cleft palate cases I would think that the largest group of these cases have been treated up until now in the cleft lip and cleft palate unit under the Research Institue at the Hospital for Sick Children, which, as you know, has been established for some time. This was basically a research unit under, I believe, some support from the Atkinson Foundation and is in the process at the moment of being changed to a clinical unit, I believe.

There have been also a number of cleft

Mr. AMES: The two programs are quite similar, but in the application of those programs there are quite a number of differences. Therefore I would certainly hope that even though the two of them would be considered together there would be more difference so that the needs of the crippled child versus the needs of the cerebral adult would be taken into account.

COMMISSIONER HEMSTOCK: Thank you very much, sir.

COMMISSIONER STRACHAN: Mr. Chairman, gentlemen, I note in paragraph 8 that cleft lip and/or cleft palate are included in your definition of crippled child. I note that you have had 1,237 such cases with 179 new cases last year. Where are these children treated and is the new treatment centre equipped and staffed to handle these cases?

Mr. WHALEY: Mr. Lewthwaite will answer that, Mr. Chairman.

Dr. DAVIDSON: Mr. Chairman, in answer to Commission Strachan's question, in answer to the cleft lip and cleft palate cases I would say that the larger group of these cases have been treated up until now in the cleft lip and cleft palate unit under the Sessions Institute at the Hospital for Sick Children, which, as you know, has been established for some time. This was actually a research unit under, I believe, some support from the Ontario Foundation and is in the process at the moment of being changed to a clinical unit, I believe.

There have been some a number of last

lip and cleft palate cases treated in some of the centres, particularly Ottawa, the head of the lakes and Sudbury, and we have had a cleft palate unit team from the Hospital for Sick Children go to these various areas to assist in establishing their particular program.

The Ontario Crippled Children's Centre is very much interested in this particular program, and we will be and are in the process of setting up a program for the cleft lip and cleft palate program at the Cripple Centre. This is by mutual arrangement with the present cleft lip and cleft palate unit at the Hospital for Sick Children, and the professor and his staff of the Faculty of Dentistry at our dental college here.

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DR. DAVIDSON: These three units will, in fact, complement one another. The Hospital for Sick Children, first of all, in this unit, does not take care of all the present health problems of the province and some of them will be referred directly to our centre. The Dental College, Dental Faculty, are interested in this basically from a teaching program and for facilities for teaching that they don't particularly wish to set up in their own centre from a treatment point of view because they don't have sufficient research and post-graduate dental men to involve themselves in this program.

Basically our staff will be the same in the three units. Our pedodontist is half-time on the Faculty of Dentistry in the University of Toronto and half-time with the centre. The orthodontist is presently involved in the university program in the Hospital for Sick Children. We expect to have another orthodontist when he returns from his post-graduate work, who will probably work in all three units.

As far as our plastic surgeons are concerned, our plastic surgeons are also members of the research institute unit on the Hospital for Sick Children and we have, additionally, plastic surgeons from the city who are on other hospitals are interested in this work, so that we anticipate this will be a very major aspect of our program, particularly in relation to the orthodontic and post-dontic problems that will arise.

COMMISSIONER STRACHAN: Thank you, sir.

Davidson .....

Mr. [illegible]: Does these units will,
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concerned, our plastic surgeons are also members of
the staff with [illegible] the Hospital for Sick
Children and [illegible], and [illegible] [illegible]
from the [illegible] are [illegible] [illegible] [illegible]
in this [illegible], so that we [illegible] [illegible] is a
very [illegible] of our [illegible], particularly in
[illegible] in the [illegible] and [illegible] [illegible]
that [illegible].

[illegible] [illegible] [illegible], [illegible].

In reference to your treatment service in paragraph 15, many factors are mentioned. Do you give your regular patients normal dental treatment and where is it given, how do they receive it?

DR. DAVIDSON: At the Ontario Crippled Children's Centre our dental staff are interested, first of all, in the oral hygiene of the children in the hospital. That is their first concern. Their second concern is, as far as our dental department is concerned, any child who has a major problem as far as dental work is concerned, and I am thinking particularly of those children with cerebral palsy, particularly the apathoid where it is impossible to get that child into a dental chair under ordinary circumstances. He may be referred by his dentist to our centre so that the child may have that dental care, under those particular circumstances, and our dental department is set up to provide general anaesthesia for the child with a proper recovery room and the necessary facilities.

COMMISSIONER STRACHAN: That was the answer I was hoping to hear.

DR. DAVIDSON: You may be interested to know, sir, our Advisory Committee is a Medical-Dental Committee.

COMMISSIONER VAN WART: Just a couple of minor points. One is No. 30, regarding your camps. I happen to be especially interested in the camps because I initiated a camp in New Brunswick. How long are the children kept in these camps?

MR. AULD: It depends on the age group,

In response to your inquiry regarding is, [illegible] are much used. [illegible] you bring your regular patients normal dental treatment and where is it given, how do they receive it?

Dr. [illegible]: In the Dutchie Crippled Children's Centre our dental [illegible] are interested, first of all, in the [illegible] welfare of the child upon in the hospital. That [illegible] first concern. Their second concern, as far as our dental department is concerned, any child who has a major problem as far as dental work is concerned, and I am thinking particularly of those children with neglected palate, particularly the [illegible] where it is impossible to get that child into a dental chair under ordinary circumstances. He may be referred by his doctor to our centre so that the child may have that dental care, under these particular circumstances, the [illegible] is set up to provide general anaesthetic for the child [illegible] recovery room and the necessary facilities.

[illegible] CHAIRMAN: That was the answer I was [illegible] to hear.

Dr. [illegible]: You may be interested to know, sir, our [illegible] committee is a Medical-Dental Committee.

[illegible] Vice-Chairman: Just a couple of minor points. [illegible] Dr. [illegible] your [illegible]. I happen to be [illegible] presented [illegible] because I initiated a [illegible] in my [illegible]. How long are the children [illegible] in these cases?

Dr. [illegible]: It depends on the [illegible],

sir, but in most cases it is for a three-week period. We start in on June 9th of this year with a young adult group for two weeks, and then we swing into the children for the balance of the season, again usually a three-week period.

COMMISSIONER VAN WART: You have separate camps for the boys and girls or do you have mixed camps?

MR. AULD: We have five camps altogether, sir, and one of which we have been conducting mixed groups in the younger years, in other words, the 7 to 9, 10. We have been mixing them as an experiment and it has worked out very well and we are considering expanding this into the other camps.

COMMISSIONER VAN WART: Do you have a rehabilitation program carried out during that three-week period?

MR. AULD: No, sir.

COMMISSIONER VAN WART: Arts and crafts and so on?

MR. AULD: It is an informal program, sir. There are no formal therapies carried out at our camps at all. What we try to do is to put into practice in an informal way all the things that have been going on in their formal treatment program during the balance of the year. As an example, by virtue of a baseball game, the very things the child has been learning or trying to learn in the physiotherapy department, the counsellors try to encourage that particular child to exercise; for example, if it is a post-polio with a

sir, but in most cases it is for a three-week period. We start in on June 4th of this year with a young adult group for two weeks, and then we swing into the children for the balance of the session, again usually in [illegible]

COMMISSIONER VAN WAGT: You have separate camps for the boys and girls or do you have mixed camps?

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leg which is crippled, then naturally by getting him to walk or to run or hobble around the bases this is, in effect, carrying out what the physiotherapists were trying to do in the formal treatment.

COMMISSIONER VAN WART: Your camp administrators; do they have special training courses? I don't mean the counsellors. I mean the administrators of the camp.

MR. AULD: All of our camp directors, sir, are nurses who either have had previous experience in camps or, if they haven't, we give them some form of indoctrination.

COMMISSIONER VAN WART: Turning now to your next section, Section 32, your special holidays for severely handicapped. What form does that holiday take?

MR. AULD: Depending on the need, sir, it is for the very severely involved child who is not going to get too much benefit out of a full camp program. We either arrange for a homemaker to go into the home and thereby relieve the mother, particularly the mother, and the rest of the family, enabling them to get away for a holiday, or we can arrange for a boarding home under our supervision for that particular child for two, three or longer weeks depending on the need of, mostly, the mother.

COMMISSIONER VAN WART: Is that service very large?

MR. AULD: It has only been in effect two or three years. Last year, as I recall it, I

leg which is amputated, then naturally by getting him to walk or to run or bicycle around the block this is, in effect, carrying out what the physiotherapists were trying to do in the formal treatment.

COMMISSIONER VAN WART: Your camp administrators; do they have special training courses? I don't mean the counsellors. I mean the administrators of the camps.

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COMMISSIONER VAN WART: Is that service very large?

Mr. AULD: It has only been in effect two or three years. Last year, as I recall it, I

believe there were 80 cases and it is expanding all the time as it becomes known.

THE CHAIRMAN: Dr. Baltzan?

COMMISSIONER BALTZAN: Gentlemen, your work can be divided into two very large sections: one is corrective and the other is restorative rehabilitation; am I right in that, sir?

MR. AULD: Yes, sir.

COMMISSIONER BALTZAN: And the corrective can go from foot to head, say, from bunions and club feet to hydrocephalus?

MR. AULD: That is right.

COMMISSIONER BALTZAN: When this vital surgery or orthopaedic surgery or dental surgery has to be performed on your children up to 19 years of age, is it a great strain on your resources, I mean your financial resources?

DR. DAVIDSON: Mr. Chairman, in answer to Dr. Baltzan's question, we are in the very happy position that our physicians and surgeons do not make any charge for this surgical procedure to the Ontario Society. We don't pay the medical and surgical fees as such. These are generally done on a public ward service in our various hospitals or if they are not done they are generally done by the physician or surgeon without charge.

COMMISSIONER BALTZAN: As a gratuity and a contribution to your work?

DR. DAVIDSON: As a contribution to his community, yes.

COMMISSIONER BALTZAN: Thank you. Just one other minor point: on page 3, I don't seem to understand in 9(1) these figures exclude children in the City of Toronto who are visited by public health nurses in the Department of Health.

MR. AULD: Sir, we have an arrangement whereby the Department of Health of the City of Toronto assumes the responsibility for visiting the crippled children in the city. However, if the public health nurse feels that there is a particular problem that requires attention then she calls on our own public nurses who have special training in this line so that we don't take exactly the same responsibilty in the City of Toronto as we do in the rest of the province.

COMMISSIONER BALTZAN: When it comes to offering treatment or instituting rehabilitation procedures, it is still available?

DR. DAVIDSON: Our services are available.

COMMISSIONER BALTZAN: All your services are available to the children in Toronto?

DR. DAVIDSON: Correct, sir.

COMMISSIONER BALTZAN: That is fine. Thank you, sir.

2 THE CHAIRMAN: Thank you very much, Mr. Whaley, Dr. Davidson and gentlemen. As you can appreciate, we are greatly interested in the work of your Society. We are impressed with the devotion to the work the Society is carrying out by the many volunteers who work for it. We are grateful to you for

having prepared this brief which contains a lot of information that we haven't dealt with specifically but which will be of value to our research people.

Thank you for your attendance here this morning.

MR. WHALEY: Thank you, sir, for your kind indulgence in listening to us. We do represent a very large group in the province of voluntary workers. We are pleased to be here. Thank you.

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THE SECRETARY: Mr. Chairman, the next submission is that of the Ontario Association for Emotionally Disturbed Children. It will be known as Exhibit 304 and will be taken into the record. As it is only four pages I would suggest the total submission be placed on the record.

THE CHAIRMAN: What about the appendices attached?

THE SECRETARY: I would suggest the appendices be carried as part of the exhibit.

THE CHAIRMAN: We will make the appendices Exhibit 304A and only 304 goes into the record.

--- EXHIBIT NO. 304: Submission of the Ontario Association for Emotionally Disturbed Children.

--- EXHIBIT NO. 304A: Appendices to above submission.

SUBMISSION OF THE ONTARIO ASSOCIATION FOR EMOTIONALLY DISTURBED CHILDREN.

Mr. Chairman and Members of the Commission:

1. The Association (Appendix A)

The Ontario Association for Emotionally Disturbed Children is an association chartered by the Province of Ontario as a charitable organization to work for its avowed aims towards:

(1) greater understanding in the community for emotionally disturbed children; and

(2) help in establishing and maintaining

facilities for diagnosis, research, treatment and education of, and for mentally ill children.

2. Our membership includes parents, psychiatrists, social workers, teachers and other persons professionally and non-professionally involved in the care of emotionally disturbed children. The core is the parents of severely disturbed children.

3. We respectfully present this brief as a lay view of the questions faced by parents of, and workers for emotionally disturbed or mentally ill children.

4. Incidence and Description (Appendix B)

It is believed in the Western world, where statistics are available, that about 7% to 10% of the child population will need some form of mental or emotional help, that 4% to 6% are seriously maladjusted, and that 1% to 2% are extremely disturbed. This means that, in the school systems, four or five children in the average classroom will need individual assistance, and that two or three children will be seriously handicapped by reason of emotional problems.

5. In addition, there are many children who are entirely excluded from the school systems, and who are so seriously disturbed as to be grouped with the defective and retarded children. Of these, some are kept at home without service; a few are sent to special schools, privately established, where fees range from $4,500 to $6,000 annually; a small number, wards of Children's Aid Societies, are sent to

facilities for diagnosis, research, treatment and evaluation of, and for emotionally ill children.

2. Our membership includes parents, psychiatrists, social workers, teachers and other persons professionally and non-professionally involved in the care of emotionally disturbed children. The core is the parents of severely disturbed children.

3. We respectfully present this brief as a review of the questions faced by parents of, and workers for emotionally disturbed or mentally ill children.

4. Incidence and description (Appendix I)

It is believed in the Western world, where statistics are available, that about 7% to 10% of the child population will need some form of mental or emotional help, that 4% to 6% are seriously maladjusted, and that 1% to 2% are extremely disturbed. This means that, in the school system, four or five children in the average classroom need individual assistance, and that one or two children will be permanently handicapped by reason of emotional problems.

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children who are autistic [illegible] need [illegible] school [illegible] [illegible] class, [illegible] treat [illegible] special [illegible] less [illegible] (from [illegible] to 10, [illegible] a small number, [illegible] of [illegible]

residential treatment centres; but a great many are inappropriately placed in custodial care in the Ontario Hospital Schools.

6. Present Facilities

In the seriously overcrowded and understaffed conditions in which they operate, the Ontario Hospital Schools are doing the best that can be done. But there are many children in the Hospital Schools who would benefit from psychiatric treatment, but who now receive little or none.

7. There is in Ontario, one hospital for the treatment of mentally ill children at Thistletown, its maximum capacity, dismayingly inadequate, 65. The Department of Health has also established a Psychiatric Research Institute in London, one of whose functions is to investigate and encourage alternate forms of care and other community services. The Department alone cannot provide, quantitatively, for emotionally disturbed children in Ontario. Individual communities will need to initiate and promote centres for this service, by the same methods which operate for general hospitals.

8. There are very few facilities in this province which provide the kind of professional skill and staff-child ratio which would classify them as residential treatment centres. Treatment centres are, by design and of necessity, small, and their present aggregate population represents principally that group of very disturbed children who are wards of Children's Aid Societies. Such treatment centres receive only very minor grants and, being under the

Department of Welfare, no hospital insurance. In consequence, the cost of sending one's own child to such a centre is prohibitive to the average parent.

9. Fields for Improved Facilities

It would appears that help for the disturbed child can best be made available to the family and community through team work by psychologist, social worker and child care worker, led by a well-trained and fully qualified psychiatrist. If this help were ready at all times, many disturbed children could be kept at home, rather than 'dumped' in hospital schools which are in many of these cases, used only for custodial care. The schools could then be used to greater benefit for the purposeful training of the retarded and brain-damaged child.

10. More local and regional teams in a province of 400,000 square miles would prevent the emotional damage to the child induced by the long-term separation from family and home where these are remote from hospital schools and treatment centres.

11. Pressure on the few clinics now established means a delay of from one to six months in reception, and a necessary but heartbreaking rejection of the case requiring long-term treatment. Establishment of more regional clinics adequately staffed, possibly attached to local hospitals or school system administrations, would relieve the pressure, cut the delay, and ensure more help for local children.

12. Increased establishment of regional clinics could not help but increase local

[illegible] of [illegible], no hospital treatment. In consequence, the cost of sending one's own child to such a centre is prohibitive to the average parent.

9. Facilities in Approved Facilities

It would appear that help for the distur[illegible] child [illegible] be more available to the family and community through team work by psychiatrist, social worker and child care worker, led by a well-trained and fully qualified psychiatrist. If this help were ready at all times, many disturbed children could be kept at home, rather than 'housed' in hospital wards which are in many of these cases, used only for custodial care. The [illegible] could then be used to greater benefit for the purposeful training of the retarded and brain-damaged child.

10. More Local and Regional Centres

A pop[illegible] of 150,000 square miles would prevent the emotional damage to the child caused by the long-term separation from family and home where the [illegible] from hospital [illegible] and treatment centre.

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12. Increase [illegible] of [illegible]

[illegible] [illegible] [illegible] [illegible]

awareness, in physicians, teachers and other adults working with children, an awareness that would lead to much earlier diagnosis. Early diagnosis could lead to a much shorter term of necessary treatment, and to a better chance of total rehabilitation.

13. The knowledge gained by the work of regional clinics would help in the research vitally necessary in finding the answers to the problems of caring for the emotionally disturbed child.

14. Recommendations

This Association therefore respectfully submits that the following needs require urgent consideration:

(a) Greater in-training inducements for the child psychiatrist, who, to be fully qualified, must go through at least five years post-graduate work, and seven if he wishes to be a qualified paediatrician as well;

(b) Greater inducements and more training opportunities for the child care worker, in order that standards of care may be steadily improved (Appendix C);

(c) Greater facilities for local and regional mental health teams to operate under the leadership of qualified psychiatrists.

awareness, in physicians, teachers and other adults working with children, an awareness that would lead to much earlier diagnosis. Early diagnosis could lead to a much shorter term of necessary treatment, and to a better chance of total rehabilitation.

13. The knowledge gained by the work of regional clinics would help in the research vitally necessary in finding the answers to the problems of caring for the emotionally disturbed child.

This Association therefore respectfully submits that the following needs require urgent consideration:

(a) Greater in-training inducements for the child psychiatrist, who, to be fully qualified, must go through at least five years post-graduate work, and seven if he wishes to be a qualified paediatrician as well;

(b) Greater inducements and more enabling opportunities for the child care worker, in order that at present of care may be usually improved (Appendix C);

(c) Greater facilities for local and regional mental health teams to operate under the jurisdiction of

THE SECRETARY: The next submission, sir, is the Canadian Public Health Association. It will be known as Exhibit 305 and Dr. E.J. Young will introduce his group.

---EXHIBIT NO. 305: Submission of the Canadian Public Health Association.

SUBMISSION OF

CANADIAN PUBLIC HEALTH ASSOCIATION

APPEARANCES: Dr. W.G. Brown
Dr. J.E.F. Hastings
Dr. E.J. Young

DR. YOUNG: Mr. Chairman, my colleagues are Dr. Gordon Brown on my left, who is the President of the Canadian Public Health Association, and Dr. John Hastings on my right, a Member of our Committee which prepared this brief.

I would like, when it comes to question time, to call on them to answer appropriate questions, so I will proceed with our summary statement.

The Canadian Public Health Association is a national professional health organization. Its headquarters is here in Toronto.

The objects of the Canadian Public Health Association as stated in its Charter are "The objects of the Association shall be the development and diffusion throughout Canada of the knowledge of public health and preventive medicine and all other matters and things appertaining thereto, or connected therewith".

The members of the Association belong to all the disciplines concerned with the health of the

--EVE. SESS. 9:00: Submission of the Canadian Public Health Association.

DISCUSSION OF

CANADIAN PUBLIC HEALTH ASSOCIATION

PRESENT:

Dr. J.D.T. Hastings
Dr. E.J. Young

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The objects of the Canadian Public Health Association as stated in its Charter are "The objects of the Association shall be the development and diffusion throughout Canada of the knowledge of public health and preventive medicine and all other matters and things appertaining thereto, or incidental thereto."

The message of the Association relates to all the disciplines concerned with the health of the

people of Canada and include physicians, dentists, veterinarians, engineers, laboratory scientists, nurses, health service administrators, statisticians, health educators, social scientists, sanitary inspectors and others. Included are members of official health agencies at all levels of government, professional and technical persons who are engaged in a broad area of health services, members of voluntary agencies and a number of interested lay people who are concerned with the general health and well being of the public. Some of our members are associated with educational and research institutions.

The Canadian Public Health Association is a national organization. It is apparent from its objects and the multi-discipline nature of its membership that it has a broad field of interest in the health of the people of Canada. Detailed information regarding the development, organization, philosophy and scope of activities of the Association are contained in the Appendix.

The Association does not intend in this Brief to attempt to deal with all the elements of health services or health needs but rather with those features which it considers itself to be in a unique position to present and which it feels call for particular emphasis. Furthermore, the Association does not propose in this Brief to duplicate or combine the thinking of those of its provincial branches, divisions or affiliated associations who have or will be speaking for themselves concerning their own specific provincial needs.

groups [illegible] include physicians, dentists, veterinarians, engineers, laboratory scientists, nurses, health care administrators, statisticians, lawyers, economists, social scientists, sanitary inspectors and others. Included are members of official health agencies at all levels of government, professional and technical personnel who are employed in broad areas of the health services, members of voluntary agencies and a number of interested lay people who are concerned with the general health and well being of the public. Some of the members are associated with educational and research institutions.

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The Association [illegible] it [illegible] to [illegible] the concept of health [illegible] those [illegible] principles to [illegible] which [illegible] potential [illegible], the [illegible] in this [illegible] of all [illegible] for themselves, [illegible].

While the Association proposes to focus attention on needs, it also wishes to record its belief that very great progress has been made in Canada in the health field. However, our accomplishment must not lead to complacency and the future holds great challenge and opportunity.

The material in this Brief will be set out in the following order, first a summary of conclusions and recommendations followed by information supporting each of these. Further details are contained in an appendix.

Conclusions and Recommendations

The Canadian Public Health Association believes that Canada should adopt a more positive philosophy towards health. It considers that services for prevention and public health need a great deal more support, and it recommends to the Commission that these features receive emphasis in its proposals. Furthermore, it believes it will be extremely important to assure a proper balance in the future development of health services in Canada. It urges that any proposals in this regard stress the development of services, training and research and are not confined to fiscal proposals.

The Canadian Public Health Association believes that health legislation in Canada requires a complete overhaul. It is assuming a "patchwork" character. Many of the statutes are obsolete, cumbersome and require complicated interpretation and frequently make it difficult to achieve the objectives of the health program. In a Federal State such as

Canada it is extremely important that there be a basic uniformity in health legislation to facilitate action at all levels.

This Association fully recognizes that health in Canada is a matter of provincial jurisdiction and nothing in this submission is intended to challenge the existing division of responsibilities.

This Association only advocates that opportunities be provided for the provincial health authorities to develop common principles and common modern approaches to be embodied in the new provincial health statutes.

Therefore the Canadian Public Health Association wishes to draw to the attention of the Commission, the importance of careful appraisal of health legislation in Canada so that future programs will not be impeded by faulty and obsolete legislation.

The Association believes that administrative arrangements should facilitate co-ordination and that fragmentation of health services responsibility should be minimal and that administrative responsibility should be specifically defined.

It therefore recommends to the Commission that in its assessment of existing health services and its consideration of plans to meet extended or new health services needs, this fragmentation of responsibility be avoided whenever possible in the best interests of efficiency and economy.

The Canadian Public Health Association considers that the long term planning and evaluation of health arrangements are most important and deserve a

great deal more attention in future. It considers that health indices are required in order to appraise and assess our health needs and to evaluate the availability and use of health resources.

It therefore recommends that the Royal Commission (1) Recognize (a) planning as an essential part of the development and administration of health services in Canada; and (b) that this continuing function requires at least on the national and provincial levels, full-time competent staff with appropriate professional training and experience.
(2) Recommend support for (a) the more extensive application of available health data to planning, administration and evaluation of health services; (b) research into the improvement of present health indicators and the identification and production of further indices of health needs and the effectiveness of health services in meeting them.
(3) Recognize and emphasize the importance of evaluation procedures generally and their incorporation into plans for new and expanded services.

The Canadian Public Health Association believes that there is considerable scope for effective application of preventive services beyond that which is presently being provided. The Association therefore recommends to the Commission that in order that the Canadian people may reap the full health and economic benefits of preventive health services that these services be given greater emphasis in terms of program, facilities and financial support.

The Canadian Public Health Association believes that greater emphasis should be placed on services for the control of chronic disease and the provision of comprehensive rehabilitation facilities. It considers that these phases of health services are investments that will pay rich dividends and that expenditures that may be involved will be returned many fold. It further believes that public health personnel can fulfill several useful functions in connection with these services.

The Association therefore recommends to the Commission that the relatively underdeveloped health services of chronic disease care and rehabilitation receive the emphasis and support which they obviously deserve.

With respect to mental health services as the Canadian Public Health Association believes in the following trends, namely:

- progressive integration of psychiatric with medicine,
- increased integration of psychiatric treatment services with general hospital treatment services.
- movement away from the custodial approach, attitude and type of institution,
- development of small regional psychiatric clinics and units to place diagnostic and treatment services closer to the people,
- integration of mental health facilities with all other related community facilities.

concentration on early diagnosis, early active treatment and effective rehabilitation designed to maintain and keep the affected person in his home, his job and his community.

The Association therefore, recommends that when the Commission is giving consideration to plans to meet future needs of the Canadian people with respect to mental health care that these trends be kept prominently in mind.

The Canadian Public Health Association is concerned with Health Services Research. It desires to give its support to programs designed to provide a comprehensive extension of medical research in Canada particularly those associated with diseases of public health significance. It believes that there is a need specifically for "operational research" which is designed to appraise and assess programs and develop techniques for functional improvement. It also considers that it is important to foster a career service for research workers in order to attract and retain competent people in Canada in this highly important field.

The Association, therefore, recommends to the Commission that it give consideration to more support being provided for research of diseases of public health significance, to operational research and of a career service for research workers.

As the Canadian Public Health Association believes that one of the barriers to future progress will be the availability of adequately trained

(c) concentration on early diagnosis, early active treatment and effort at rehabilitation on other measures to maintain and keep the affected person in his home, his job and his community.

The Association, therefore, recommends that when the Commission is giving consideration to plans to meet future needs of the Canadian people with respect to mental health care that these trends be kept prominently in mind.

7. The Canadian Public Health Association is concerned with Health Insurance planning. It desires to give its support to programme designed to provide a comprehensive extension of medical research in [illegible] particularly those associated with diseases of public health [illegible]. It believes that there is a need specifically for [illegible] (systems) to appraise and assess programs and develop techniques for their continuing improvement. It also considers that it be incumbent [illegible] a primary agency for research [illegible] and health competent people [illegible]

8. [illegible]

To the [illegible]

support [illegible]

public health services, [illegible]

[illegible]

9. [illegible]

[illegible] believes [illegible]

program [illegible] be the [illegible]

personnel it believes that the Commission should be concerned not only with the number trained but also with the type and quality of training which is being provided. The Association wishes to stress the need for health personnel in the many disciplines associated with public health. It also considers that insufficient attention is being given in the basic training of the health professions in prevention and public health procedures.

The Association therefore recommends that the Commission include in its educational proposals that undergraduates in the health disciplines receive adequate training in public health and preventive medicine; that the two Canadian schools of hygiene be given adequate support in maintaining their existing educational programs, in meeting additional needs and in conducting refresher courses; and other provinces in addition to Ontario and Quebec be encouraged to provide facilities for the formal training of sanitary inspectors and that support and encouragement be given to members of the health disciplines entering the fields of public health and preventive medicine.

The Canadian Public Health Association believes that there is an urgent need for the development of a career service in public health in Canada. It further believes that such a service should provide interesting and challenging work, opportunity for advancement, training privileges and adequate reumuneration.

The Association therefore recommends

that the Commission incorporate in its recommendations the development of such a service which would include an assurance of interesting and challenging work; opportunity for advancement; training privileges; and adequate remuneration.

The Canadian Public Health Association believes that any consideration of existing or future health services in Canada should include plans for the maintenance of health, prevention of disease and medical care of casualties in time of disaster whether it be from natural causes or as a result of international events including nuclear attack.

In view of this belief the Association recommends that the Commission in its consideration of existing and future health services include emergency health services and give support to the planning for and organization of these services across Canada.

THE CHAIRMAN: Thank you very much Dr. Young. Is there anything that you may wish to add by way of comment, or either of your associates may wish to add at this time?

DR. YOUNG: Apparently not sir.

THE CHAIRMAN: I am going to ask Dr. Firestone if he would open the discussion on your presentation here this morning.

COMMISSIONER FIRESTONE: Dr. Young, when I am addressing questions to you, please feel free to call on your colleagues to answer any of the questions as may be appropriate.

My first question relates to paragraph

that the commission recognizes the accomplishments of the dental profession in providing such programs as assistance of indigents in challenging work, opportunity for advancement, adequate supervision and [illegible]

The Canadian Dental Health Association believes that any consideration of extension of dental health services in Canada should include plans for the maintenance of health, prevention of disease and medical care or consultation [illegible] from natural causes [illegible] as a result of international [illegible] events including modern attack.

In view of the above the association recommends that the commission in its consideration of existing and future health services include emergency health services and give support to the planning and organization of these services [illegible]

Dr. [illegible], [illegible] you very much.

Dr. Young. Is there anything that you may wish to add by way of comment, [illegible] associations may wish to add at this time?

Dr. Young. Absolutely [illegible]

The Chairman. I am [illegible]

Mr. Fitzpatrick. [illegible] to discussion [illegible] presentation here today.

[illegible]

When I am [illegible] questions to [illegible], I [illegible] free to call on your colleagues to answer any of the questions as they go along.

My first [illegible] is [illegible]

2 on page 1. You say, and I quote:

"That it will be extremely important
"to assure proper balance in the future
"development of health services in
"Canada",

and the emphasis as I understand it is placed on the phrase "proper balance", and you elaborate in paragraph 3 that the present situation apparently is not well balanced. You point out that expenditures on public health services are about one-fifteenth of total expenditures on personal health services.

What would be your definition of a proper balance? Should the ratio be changed in the next few years to one-tenth from one-fifteenth, or should the ratio remain? What is a proper balance in your view?

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DR. YOUNG: Well, I think the requirement here is to look after the many gaps that there are in the health programs across the country. I think it would be pretty hard to tie it down. But in talking about this to one of our consultants we felt that if the figure here for public health services was probably doubled that would go a long way towards providing a proper balance in health services. But our main concern here was that as the health services of the country develop public health and preventive medicine is not lost sight of, and there has been so much money spent on hospital services and other things that it does not get its proper share.

COMMISSIONER FIRESTONE: You would therefore feel that if there is a program planned for the future of comprehensive health care services for Canada, that somewhat greater emphasis should be placed on public health services and preventive medicine than has been the case so far. Am I correct in that understanding?

DR. YOUNG: That is true.

COMMISSIONER FIRESTONE: And that this would be reflected in the somewhat greater proportionate increase in expenditures for public health services and related services.

DR. YOUNG: That is the Association's belief, as far as I know, sir.

COMMISSIONER FIRESTONE: May I now turn, sir, to Page 3, Paragraph 12. You say:

"Not only is it important to provide for the

Dr. [illegible]: Well, I think the

[illegible] are to look after the [illegible] that there are in the health programs a more [illegible]. I think it would be pretty hard to [illegible] anything about this in one of our consultants [illegible] but it the [illegible] for public health services are probably [illegible] would [illegible] providing a proper balance in health [illegible]. But our main concern here was that as the health services of the country develop public health and preventive medicine [illegible] just right of, and there has been so much money spent on hospitals, services and other things that it does not [illegible] [illegible].

COMMISSIONER FIELDING: You would therefore feel that in there is a program planned for the future of comprehensive health care services for Canada, that somewhat greater emphasis should be placed on public health services and preventive medicine than has been the case so far. Am I correct in that [illegible]?

Dr. [illegible]: That is true.

COMMISSIONER FIELDING: And that this would be reflected in the [illegible] greater proportionate increase in expenditures for public health services [illegible] medical services.

Dr. [illegible]: That is the Association's belief, as far as I know, sir.

COMMISSIONER FIELDING: May I [illegible] then, sir, to page [illegible], paragraph 12. [illegible] that one is it important to [illegible] [illegible]

co-ordination of health services, but these services need to be dovetailed with our welfare arrangements."

Now, sir, we have had some presentations made to this Commission as to the difficulties that arise, that there are various agencies concerned with different aspects of health, some health proper, in the welfare field. The question arises, how would this objective which you refer to in Paragraph 12 be achieved in practice? How do you dovetail health arrangements with welfare arrangements?

DR. YOUNG: I would ask Dr. Brown to answer that.

DR. BROWN: Mr. Chairman, our concern in this matter and our reason for referring to this item is that we in our practice are very well aware that in spite of the best medical care given to many people, for a good example, tuberculosis, it can be lost as the result of failure to provide not medical assistance, but let's say, social assistance and welfare assistance, and if the health authority has to go through formalities and red-tape and all sorts of complicated procedures to get that to the person who needs it, then you lose the ultimate aim which is your objective, and therefore, we feel that it is not a combination necessarily of administration as much as the recognition of the necessity of a very close liaison by committees or at least by intimate knowledge how the machine is to operate. The public, in other words, shouldn't suffer as a result of our failure to provide for their complete assistance, whether

[illegible] Lewis

[illegible] of health services, but those
[illegible] need to be [illegible] with co
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Now, sir, we have had some presentations
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DR. YOUNG: I would ask Dr. Brown to

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[illegible] to [illegible] [illegible] needs it, then you lose the
benefits of which [illegible] your disability, and [illegible],
that [illegible] a combination necessarily of medical
[illegible] and the [illegible] of the [illegible]
[illegible] [illegible] [illegible] [illegible] [illegible]
[illegible] [illegible] [illegible] [illegible] [illegible]
[illegible] [illegible] [illegible] [illegible] [illegible]

it be welfare or health.

COMMISSIONER FIRESTONE: Is it only the problem of coordination and cooperation, or is it perhaps due to the fact that there are gaps in providing such services. As far as the Department of Welfare is concerned, it is services to indigent people. I take it that is what you mean when you speak of coordination between health and welfare agencies.

DR. BROWN: I don't think we would confine our thinking necessarily to the indigent. However, that is perhaps the main area of interest. However, the problem is providing welfare services and whether the person is in need of welfare services or is in need of health services and vocational services, and we have reference in the brief later on to this question of fragmentation which creates the situation where the only person who really suffers is the person who is in need and he suffers as a result of our division and fragmentation of our approach and our administration, and we feel that a lot could be done to bring that together.

We are perhaps not experts in the planning thereof, but we are convinced that it must happen or should happen.

COMMISSIONER FIRESTONE: Just trying to be practical and trying to understand the application of this principle, can we take a particular case? Let's say there is a welfare case and the person is designated as an indigent by the welfare department in Ontario. That person, I understand, gets a little card or some identification to indicate that he is entitled to medical

[illegible]

it be welfare or health.

MR. [illegible]: Is it only the problem of coordination and cooperation, or is it perhaps due to the fact that there are gaps in providing some services. As far as the Department of Welfare is concerned, it is serving an indigent people. I take it that is what you mean when you speak of coordination between health and welfare agencies.

MR. [illegible]: I don't think we would confine our thinking necessarily to the indigent. Whether that is really the main area of interest. However, the problem is providing welfare service or and whether the person is in need of welfare services or is in need of health services and vocational services, and we have referred to this later on in this question of transportation. Well, regardless the situation where the only person who really matters is the person who is in need and is entitled as a result of our division and jurisdiction, of course according to eligibility, and we feel that a lot could be done if being done together.

We have problems with cheques in the mailing department, but we do only use that after hours or month ends.

MR. [illegible]: Are there ways to be practical and try to understand the operation of this department, we have a particular area. Lots of times in rural areas and the person is described as in an income [illegible] the welfare department or [illegible] , I understand, [illegible] a little [illegible] identification [illegible] [illegible] to be [illegible]

care services. Is that the procedure?

DR. BROWN: That is so, sir.

COMMISSIONER FIRESTONE: That person then goes to the doctor in the case of illness and the doctor prescribes some drugs. What then does this medically indigent person do to obtain such drugs?

DR. BROWN: If he is unable to pay for this it would be provided through the Welfare Department and the cost paid by them.

COMMISSIONER FIRESTONE: Then this particular person goes back to the Welfare Department ---

THE CHAIRMAN: He doesn't get it automatically from possession of the card.

DR. BROWN: Not to my knowledge.

COMMISSIONER FIRESTONE: What does the Welfare Department do? It doesn't have a price tag attached to it.

DR. BROWN: I should not give you this detail in view of the fact that I am not too sure of the exact procedure. But it is done through the Department of Health.

DR. HASTINGS: Mr. Chairman, it varies a little bit from community to community, but locally in many instances the procedure is that an indigent person would get the prescription, go to the local Department of Public Welfare who would refer this to the Public Health Department locally, and if it is confirmed they would then take this prescription to, now I believe it is, any drugstore for filling. At one stage it was only certain drugstores which accepted these; now it is any in the

city. It tends to be a somewhat regional or community arrangement as to just who refers to what.

THE CHAIRMAN: How much time is involved in this manoeuvre?

DR. HASTINGS: Under this arrangement, actually for anything that is urgent they have the right to move fairly quickly and the confirmation is in a sense done afterwards to a large extent.

COMMISSIONER FIRESTONE: As I understand you, sir, first you see your doctor, then you see the Welfare Department, then you are sent over to the Health Department. What does the Health Department do? Does it check the Welfare Department or check the doctor, or check the patient? It seems a little cumbersome procedure. Forgive me for not understanding the necessity of it, and presumably there are some reasons, but I am just wondering what are the reasons.

DR. HASTINGS: I couldn't say what the reasons are; they have been developed over the years. It has been expedited where this can be done locally, so that the person is not much delayed in this city. I can't speak for other areas.

THE CHAIRMAN: When you get into the rural areas where distances become important, and so forth, the telephone communication is not quite so quick, you don't know what happens then.

DR. HASTINGS: I could not say what happens there, sir.

COMMISSIONER FIRESTONE: As you describe it to me, there seems to be some need for dovetailing.

I am just trying to see how it can be achieved in practice. Have you any further comments to offer as to how to achieve this dovetailing besides creating committees?

DR. BROWN: There is a lot, depending again on the individual involved in this, and in many areas there is a very close coordination between the welfare and health authority with the medical officer of health. A person a distance from a sanatorium states what the family needs in the way of assistance and is automatically given it and provided for, no questions asked.

COMMISSIONER FIRESTONE: That problem you raise in this paragraph could become much greater. As you know, it has been suggested to the Commission to extend the coverage to other indigent groups and medically indigent groups. So that this problem you describe here may become many times what it is at present, so your point may be well taken. But I am trying to find out just how your recommendations may be put into practice.

Would you like to give some further thought to this point, which is a very important point, and you may come forward with complete suggestions as to how this desirable objective can be translated into practice? Or does it go beyond your own terms of reference? If so, please say so.

DR. YOUNG: We would certainly be glad to do anything we can to assist the Commission.

COMMISSIONER FIRESTONE: If you prefer to consider the matter further and if you have specific

I am just trying to see how it can be achieved in practice. Have you any further comments to offer as to how to achieve this [illegible] besides creating commissions?

MR. BRUNN: There is a lot, depending again on the individual involved in this, and in many areas there is a very close coordination between the welfare and health authority with the medical officer of health. A person a distance from a centre knows what the family needs in the way of assistance and is automatically given it and provided for, no questions asked.

[illegible]

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MR. [illegible]: We would certainly be glad to do anything we can to assist the Commission.

[illegible]: If you prefer to consider the matter further and if you have social [illegible]

recommendations you will let us have these in writing, communicate with our Secretary?

DR. YOUNG: Yes.

THE CHAIRMAN: At one time they were practically combined. They were separated because of some demand, a demand that must have appeared reasonable at the time.

/hm

COMMISSIONER FIRESTONE: May I turn to paragraph 15 on page 4 in which you say:

"The Association deplores the lack "of a co-ordinating authority which "would exercise control or at least "have a direction over the voluntary "health agency field which has now "become so extensive".

How would you achieve this sort of control you are talking about in paragraph 15 over the voluntary health agencies?

THE CHAIRMAN: Perhaps it might help if you told us what you mean by voluntary agencies here.

DR. BROWN: Mr. Chairman, this reference was made because of the feeling of our committee.....

THE CHAIRMAN: Who are they?

DR. BROWN: There are so many voluntary agencies or groups that arise either as the result of individuals concerned with a given disease or handicap and they are multiplying, seem to be multiplying very extensively and rapidly and they may be involved in treatment, diagnosis or simply social assistance.

THE CHAIRMAN: Thank you very much. I think that explains what you have in mind.

COMMISSIONER FIRESTONE: Following up, how would you control it as you recommend in paragraph 15?

DR. BROWN: Mr. Chairman, I can frankly

to paragraph 1, on page 4 in which you say:

"The association believes the lack
"of a co-ordinating authority which
"would exercise control or at least
"have a co-ordination over the voluntary
"health agency field which has now
"become so extensive".

How would you achieve this sort of control you are talking about in paragraph 1, over the voluntary health agencies?

THE CHAIRMAN: Perhaps it might help if you told us what you mean by voluntary agencies here.

Dr. ROWN: Mr. Chairman, this recommendation was made because of the feeling of our committee.....

THE CHAIRMAN: Who are they?

Dr. ROWN: There are so many voluntary agencies on scores that arise sudden as the result of individuals concerned with a given disease or handicap and they are multiplying, seem to be multiplying very extensively and rapidly and they may be involved in treatment, diagnosis or simply social assistance.

THE CHAIRMAN: Thank you very much.

I think that gives us what you have in mind.

Mr. [illegible]: Thank you.

How would you combined us as you recommend in paragraph 1?

Dr. [illegible]: Mr. Chairman, I can find

say our committee struggled with this for many hours as to what type of control. We came to the conclusion it is impossible to control the public desire to spend the charitable dollar in any way which they choose.

THE CHAIRMAN: Or their own time?

DR. BROWN: We hope there would be, for instance, no duplication, a co-ordination because without doubt the charitable dollar is limited. In fact, some people say we have approached fairly close to the limits at the present time.

THE CHAIRMAN: In war-time there was control. It was achievable then. There was control over those who could solicit funds. Is it something like that you have in mind?

DR. BROWN: We don't see it is possible to apply it under peace-time conditions, let us say.

THE CHAIRMAN: It would have to be done by co-operation?

DR. BROWN: Co-operation.

COMMISSIONER FIRESTONE: By co-ordination you perhaps have in mind an appeal to the good sense of the voluntary agencies to avoid duplication to run their affairs efficiently and to tie in with some overall objective of developing and improving health services in Canada. Is that the sort of thing you have in mind when you speak of co-ordinating authority which should have some guidance or develop some co-operation among voluntary agencies. Is that what you have in mind?

DR. BROWN: To a degree that is right.

any our committee attempted with this for many hours as to what type it should be. We came to the conclusion it is impossible to restrict the public desire to spend the charitable dollar in any way they choose.

MR. [illegible]: Or their own time?

MR. [illegible]: We have there would be, for instance, a certification, a co-ordinator because without doubt the charitable dollar is limited. In fact our people are now brought fairly close to the limits at the present time.

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MR. [illegible]: We don't see it is possible to apply it under peace-time conditions, let us say.

MR. [illegible]: It would have to be done by co-operation.

[illegible]

Then you have been kind enough to the gentlemen of the voluntary agencies to avoid due notice to our [illegible] effectively and to be in with some general objective in developing and improving health services in Canada. Is that the sort of thing you have in mind when you speak of co-ordinating authority which would have some influence on avoiding some co-operation among voluntary agencies, is that what you have in mind?

MR. [illegible]: I am [illegible] that is [illegible]

Our Association at its annual meeting is deliberately making a great effort to get voluntary agencies to come in and meet with us in order to draw them, if possible, together. We do, realize, of course, incorporation of an organization or association is possible even though you might say the actual way it is going to operate has not yet been defined, so they become incorporated through their provinces or federally and then they are an organization. In one instance I recall being asked to check on one voluntary agency. I found they had three members and yet the name was quite flowery as a voluntary agency and they were soliciting funds from the public quite broadly. This can happen. How it can be controlled, I don't think we can dictate, but we can certainly make a greater effort to try and get co-ordination and understanding between these groups.

COMMISSIONER FIRESTONE: If you had a voluntary agency consisting of three members it might not produce very adequate and effective results for the purposes. Would you feel in a case like that there should be some government control to prevent misuse or misrepresentation?

DR. BROWN: It could be, sir, that might be desirable. The public wouldn't know this.

COMMISSIONER FIRESTONE: That is right.

DR. BROWN: At the time of incorporation their ultimate intent is not necessarily defined in that kind of detail. I understand this is true. In consequence appeals may be made to the public through various devices, mail or other forms of soliciting of

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Mr. [illegible]: It could be, sir, that might be desirable. The public wouldn't know this.

CHAIRMAN HUNTER: What is right.

Mr. [illegible]: At the time of incorporation that [illegible] intent is not necessarily defined in that sense or detail. I understand this is true. In consumers groups may be made to the public through various devices, mail or other forms of soliciting of

funds and apparently there are still a great many people who will give money to anything. You name it and they will give it. We know those are multiplying.

COMMISSIONER FIRESTONE: How much knowledge does your organization have of such carrying on?

DR. BROWN: Not a great deal, sir other than ones we would find in a list of organizations.

COMMISSIONER FIRESTONE: Is there any organization or any organized effort made in Canada to check on such organizations?

DR. BROWN: Not to our knowledge, sir.

COMMISSIONER FIRESTONE: Do you feel such an organized effort would be desirable whether it is through a voluntary group or through government?

DR. BROWN: We believe it would be desirable.

COMMISSIONER FIRESTONE: Thank you. May I now turn to paragraph 17 on page 4 in which you say:

"The Association believes that the
"fragmentation of health services
"responsibility should be minimal and
"that administrative responsibility
"should be specifically defined".

Then you recommend and I quote:

"One important step to accomplish this
"would be to have all official health
"activities under appropriate ministers
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Mr. BROWN: We believe it would be desirable.

COMMISSIONER FIRESTONE: Thank you. May I now turn to paragraph 17 on page 4 in which you say:

"The Association believes that the "promulgation of health services "responsibility should be minimal and "that administrative responsibility "should be specifically defined".

Then you mention and I quote:

"The important step to accomplish this "would be to have all official health "activities under appropriate ministers "of health."

Can you give us some examples of official health activities which are not under ministers of health?

DR. BROWN: I don't want, Mr. Chairman, to deal with matters that are further on in the brief. Perhaps one of the best examples was discussed in the previous brief given this morning in the field of rehabilitation where several departments of government are involved and yet we know the cause of the whole affair is medically based. Does it not follow logically coming from a medical base it should be under medical direction or health direction. We have in our association veterinarians and laboratory technicians and physicians and dentists -- they don't have to only talk about this. There is direct activity. They work for the production of an effect upon the entire community they serve.

COMMISSIONER FIRESTONE: If you could be more specific so I could visualize the achievement of this recommendation, sir, let us take the example that was discussed by the group that appeared as witnesses before you, the question of vocational training of the crippled child was brought out and the point was made this type of work is under the Department of Labour while matters relating to the health of the crippled child are under the Department of National Health and Welfare. Would your suggestion be that vocational training of the crippled child should be considered as "official health activity" and you would therefore move vocational training relating to the crippled child to the Department of Health and Welfare to administer? Is that what you have in mind?

Can you give us some examples of official health activities which are not under ministers of health?

Dr. [illegible]: I don't want, Mr. Chairman, to deal with matters that are further on in the brief. Perhaps one of the best examples was discussed in the previous brief given this morning in the field of rehabilitation where several departments of government are involved and yet we know the cause of the whole affair is medically based. Does it not follow logically coming from a medical base it should be under medical direction or health direction. We have in our association veterinarians and laboratory technicians and physicians and dentists -- they don't have to only talk about this. There is direct activity. They work for the production of an effect upon the entire community they serve.

Be more specific so I could visualize the achievement of this recommendation, sir, let us take the example that was discussed by the group that appeared as witnesses before you, the question of vocational training of the crippled child was brought out and the point was made this type of work is under the government of labour while matters relating to the health of the crippled child are under the department of national health and welfare. Would your recommendation be that vocational training of the crippled child should be considered as "official health activity" and you would therefore make vocational training relative to the crippled child to the department of health and welfare to administer? Is that what you have in mind?

DR. BROWN: That is what the Association believes, that would be an advantage.

COMMISSIONER FIRESTONE: How could this work at the provincial level where you have Health, Welfare and Education, would you move educational activities relating to the crippled child under the Department of Health?

DR. BROWN: Our Association believes it should be this way at both levels to the greatest extent possible since the whole problem of the individual -- the recipient is the important person concerned and when the recipient has to be carried medically for a time and then turned over to another person entirely who is going to carry him vocationally and yet he has to keep in contact with the medical consultants with respect to whether or not he is capable of handling the vocation chosen for him, you are going back and forth -- he is tossed back and forth and frequently he falls down between the gaps and misses out.

COMMISSIONER FIRESTONE: Would that mean that the sick person that is indigent, determination of indigency should be then tested by the health department which at the moment is the function of the welfare department?

DR. BROWN: That is difficult for me to say. I think the Welfare Department are more steeled in the determination of means tests or application of means tests than would be the Health Department.

COMMISSIONER FIRESTONEP: In other words, sir, you would judge each case on its merits,

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COMMISSIONER GRISDALE: How could this work at the provincial level where you have Health, Welfare and Education, would you move educational activities relating to the crippled child under the Department of Health?

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COMMISSIONER FITZPATRICK: In other words, sir, you would judge each case on its merits.

whether it would be a more efficient method of administration to have it done by Health you would prefer to see it there and where the division of administration is more efficient you would use that as a criterion, efficiency should be the determining criteria. Am I correct in that?

DR. BROWN: That is correct, sir, and bluntly to avoid as much shunting of the recipient as possible. It is very frustrating for many of them.

COMMISSIONER FIRESTONE: May I now turn to paragraph 18 on page 5, sir, where you state:

"Planning requires the establishment "of objectives or at least minimum "standards" ---

How do you go about finding minimum standards in the health field?

DR. HASTINGS: Mr. Chairman, this is one of these sort of general statements that appears and when one tries to define it it isn't always very easy. One might say in general terms that minimum standards are really what one would call acceptable standards and those could be defined in terms of current medical knowledge, in terms of acceptable standards by the community in terms of social and economical levels. I am thinking sir, for example, of the nursing home care field, areas on this kind. These adequate or acceptable standards could be set up which may not necessarily be optimal if one had staff facilities and funds, but nonetheless are reasonable. This again is generalizing I am quite prepared to admit.

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MR. ROWE: That is correct, sir, and bluntly to avoid as much shunting of the recipient as possible. It is very frustrating for many of them.

COMMISSIONER FERSTONE: May I now turn to paragraph 15 on page 6, sir, where you state:

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How do you [illegible] minimum standards in the health field?

MR. HASTINGS: Mr. Chairman, this is one of those sort of personal statements that appears and when one tries to define it it isn't always very easy. One might say in general terms that minimum standards are really what one would call acceptable standards and those could be defined in terms of current medical knowledge, in terms of acceptable standards by the community in terms of social and economical levels. I am thinking sir, for example, of the nursing home care field, areas on this kind. Where adequate or reasonable standards could be set up which may not necessarily be optimal if one had staff facilities and funds, but nevertheless are reasonable. This again is personalizing I am not prepared to admit.

COMMISSIONER FIRESTONE: I am trying to visualize, Dr.Hastings, and I don't want to make my question difficult for you, I am trying to see when you speak of minimum standards could it in fact be translated into practice, how would one apply that set of minimum standards to medical care service?

DR. HASTINGS: Mr. Chairman, the question of course depends to some extent upon one's point of view in this matter and as the brief which you have here,has to, of necessity, reflect a fairly diverse constituency of membership. As you are doubtless aware from the previous submission I have, along with certain other colleagues, certain definite views in this area. I don't feel it is a proper time to express these views since they essentially reflect that of a portion of the constituency. It does to a large extent depend upon one's general philosophy of what is desirable in terms of long term planning in the health field. This in turn hinges on what standards you would say would be acceptable.

COMMISSIONER FIRESTONE: Dr. Hastings, can you help me in refreshing my memory whether in the brief that was previously submitted the group you are associated with made any reference to minimum standards?

DR. HASTINGS: I am not sure we used that term. I cannot recall precisely.

COMMISSIONER FIRESTONE: That is why I felt this is a new concept and we would have liked to get some explanation. Let me tell you, Dr. Hastings, I myself have used that in my questioning of witnesses

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without having had any experts come before us that could explain that concept. You are the first group, that I can recall that has put it forward to us and it would help us to understand what we really mean when you speak of minimum standards.

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without having had any experts come before us that could explain that concept. You are the first group, that I can recall that has put it forward to us and it would help us to understand what we really mean when you speak of minimum standards.

DR. HASTINGS: Well, one could go to this extent, and say that if certain developments have taken place in medical knowledge, technique, and that sort of thing, that these should be incorporated, so that whatever program you provide incorporates the most recent knowledge within reason that you can provide.

Now, again this must be tempered by the availability of personnel, facilities and cost, but we would endeavour to keep things up to date.

This is, if you like, one form of minimum standard.

THE CHAIRMAN: Would you not look to that ideal regardless of what the planning might be leading to? You are going to have certain acceptable standards under any health services plan that would be acceptable to the Canadian people.

DR. HASTINGS: That is correct.

COMMISSIONER FIRESTONE: Well, applied to the medical care field, would the term minimum standards be equivalent to adequate medical care?

DR. HASTINGS: Mr. Chairman, this again I think is a difficult question. The Medical Care Section of the Association, of which I am Chairman, has certain views on this matter, but these may not necessarily be the views of the Association as a whole. I don't feel I can therefore answer that.

COMMISSIONER FIRESTONE: Well, you may not be able to answer it for the Association as a whole. Would you answer it with respect to the Section of which you are Chairman?

DR. MARTINS: Well, one could go to this extent, and say that if certain developments have taken place in medical knowledge, technique, and that sort of thing, that these should be incorporated, so that whatever program you provide incorporates the most recent knowledge within reason that you can provide.

Now, again this must be tempered by the availability of personnel, facilities and cost, but we would endeavour to keep things up to date.

This is, if you like, one form of minimum standard.

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VICE-CHAIRMAN TURNBOWN: Well, you may not be able to answer it for the Association as a whole, would you answer it with respect to the section of which you are Chairman?

THE CHAIRMAN: Health care would appear to be a broader expression, including more than just medical care?

DR. HASTINGS: To that extent we would regard health care as covering the whole gambit of health services, yes, and we feel that planning should keep in view all of this in proper balance.

THE CHAIRMAN: Whatever planning is done in the medical care field isn't the answer to everything?

DR. HASTINGS: No, it would be inappropriate for me to express the views of one Section at this time I think.

DR. BROWN: One thing I think, Mr. Chairman, that we had in our mind as we wrote these words was our practical experience in planning health services, and that whether it is at a local level, a Provincial level, or a Federal level, is a matter of estimates and budgets, which is one year ahead of your nose, and you are not in a position to plan ten years ahead.

If you could plan ten years ahead and get to a degree anyway your main objectives and your main principles, and as we use the word here, minimum standards of your objective, then it would be more encouraging.

COMMISSIONER BALTZAN: The medical health services that you speak of, is it public health services that you are speaking of, or personal health services?

DR. BROWN: I am now speaking of public health services. We are a public health Association,

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DR. BROWN: I am now speaking of public health services. We are a public health Association,

and our membership, a large part of them, are deeply involved in agencies that depend upon year to year estimates and budgets, and therefore year to year planning virtually.

COMMISSIONER FIRESTONE: Well, if we are talking in terms of minimum standards for health services, I presume that these minimum standards would vary, depending upon the type of health services. You would have one type for medical care service, one for dental care services, one minimum standard for the supply of drugs, one for nursing services, etcetera. So therefore, I find it, speaking just for myself, sir, difficult to envisage a concept of minimum standards that is uniform for all health services.

It seems to me that the very character of health services, each have their own characteristics, and the standards have to be designed to fit each major component of health serivces, and it was on that basis that I was seeking some guidance from you, and I appreciate the difficulties that perhaps your Association faces, since you as doctors may be representing one particular group, rather than wishing to speak for everybody that is a member of your Association, but this subject is so important that I am just wondering whether again I may pray your indulgence by asking you to consider the matter further, and to offer some advice as to what you really mean by minimum standards.

You see, sir, if we are talking of a national health care program, where the Federal Government may be making a contribution to Provincial

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Now -- sir, if we are talking of a national health care program, where the federal government may be making a contribution to provincial

plans, it may be quite important to set up certain minimum standards that the Federal Government would expect the Provincial Government plans to follow before it would make a contribution. Now, I am not saying that this is necessarily the sort of plan that might develop, but in case this sort of plan were considered, some guidance as to what is meant by this term would be helpful.

Would it be possible to give this consideration?

DR. YOUNG: We would be glad to do that.

COMMISSIONER FIRESTONE: And let us have your results in writing to the Secretary?

DR. YOUNG: Yes, sir.

COMMISSIONER FIRESTONE: When you consider this concept of minimum standards, can you also bear in mind the necessity, or the desirability, that there may be variations in such minimum standards from province to province, or there may be a minimum standard across Canada with some provinces wishing to have a higher than what you consider a minimum standard, that there be a certain flexibility.

THE CHAIRMAN: I would hate to see anybody starting with that premise, that you were going to have different minimum standards in different provinces. I think in any concept of an efficient health services plan we ought to start with the idea that any minimum there is will be the minimum, and any province that saw fit to go higher is free to do so, but I don't think we should approach it on the basis, and I would hate to see

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Mr. YOUNG: We would be glad to do that.

Have your results been writing to the Secretary?

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you gentlemen approach it on the basis, that what is good enough for Canadians in one section, others in other sections may have to do with less.

COMMISSIONER FIRESTONE: I was going to turn it around. I was going to say that there would be a minimum standard across Canada, but in developing such minimum standards you should bear in mind that some provinces might wish to have higher minimum standards.

May I turn now to Paragraph 21 on Page 6. You say, and I quote: "We are still largely dependent on mortality statistics, which although they have proved most valuable in the past, must now be reinforced by morbidity and other data". What other data do you have in mind?

DR. YOUNG: I think there we have in mind that there is a great need for morbidity statistics, for having an accurate appraisal of just what the health of the country is. It is true there was a Canadian Sickness Survey a few years ago ---

THE CHAIRMAN: In 1951, yes.

DR.YOUNG: But we feel that the information, certainly the coordinated and reported information, is very patchy as far as the morbidity of the health of the people of Canada is concerned.

COMMISSIONER FIRESTONE: Yes, you say quite specifically that you wish comprehensive and high-quality morbidity statistics, but you also suggest other data in addition to that. I just wondered what you had in mind when you speak of other data, and again if you wish to take this question under advisement and let us

Young 1.1.1

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know your answer later, that would be quite all right.

THE CHAIRMAN: Perhaps it might have been just a little bit of redundance.

COMMISSIONER FIRESTONE: May I now turn to Page 15, Paragraph 57. At the end of the paragraph you make the observation, and I quote: "With specific reference to research it must be said that it cannot thrive so long as it must be parasitic". I am just wondering what kind of research grants would you feel should be made available so that research will not be parasitic?

DR. BROWN: This reference, Mr. Chairman, arose from members who were vitally concerned and involved in areas of both teaching and research and the fact that unfortunately, and we feel it is unfortunate, research frequently is dependent upon teaching employment, or employment for teaching, or vice-versa, and when this is so, either one or the other is bound to suffer, and therefore we feel that they should be not dependent upon one or the other, although they should be involved, they should stand on their own feet, and be supported on their own feet.

In other words, a researcher should not be a researcher on the basis that he is being paid out of teaching funds or educational funds, or vice-versa.

COMMISSIONER FIRESTONE: In other words, you envisage the granting of research fellowships, or whatever you want to call them, solely for research, with no other strings attached to them?

DR. BROWN: That is so, sir, and we go

Then your answer later, that would be quite all right.

MR. [illegible]: Perhaps it might have been just a little bit of redundance.

COMMISSIONER FITZGERALD: May I now turn to Page 15, Paragraph 2. At the end of the paragraph you make the observation , and I quote: "With specific reference to research it must be said that it cannot evolve so long as it must be parasitic". I am just wondering what kind of research grants would you feel should be made available so that research will not be parasitic?

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COMMISSIONER FITZGERALD: In other words, you envisage the question of research fellowships, or whatever you want to call them, solely for research, with no other strings attached to them?

Dr. [illegible]: That is so, sir, and we go

so far as to say there should be encouragement of career researchers. So many young people in research just coming up into the field are rapidly discouraged by the fact that they don't know, when the fiscal year is approaching, they don't know whether they will be employed in the coming year or not, and there is not the assurance of continuity or career that perhaps we could provide for them.

COMMISSIONER FIRESTONE: If I understand you correctly, sir, you are really going further. You are saying that what is needed is continuing research funds to support a research program that will employ researchers on a continuing basis in this particular field?

DR. BROWN: I think it is perhaps a reference in a way to the practice, which is limited to block grants, that I think you have perhaps discussed at other times.

COMMISSIONER FIRESTONE: In Paragraph 58, sir, you speak of the necessity for more operational research in the field of public health. How much money is currently spent on operational research in this field in Canada? Do you know that amount?

DR. YOUNG: I don't know that, sir, but I would think it is very little. It is quite a new application I think, operational research in health.

DR. HASTINGS: I cannot, Mr.Chairman, give you a specific figure, but I would say from my own knowledge that there are very few projects which would really qualify under this term. The study in the Province of Nova Scotia which is mentioned in this brief,

so far as to say there should be encouragement of career researchers. So many young people in research just coming up into the field are really discouraged by the fact that they don't know, when the fiscal year is approaching, they don't know whether they will be employed in the coming year or not, and there is not the assurance of continuity or career that perhaps we could provide for

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MR. TOMKO: I don't know that, sir, but I would think it is very little. It is quite a new application - this, operational research in health.

DR. MCGINNIS: I cannot, Mr. Chairman, give you a specific figure, but I would say from my own knowledge that there are very few projects which would really qualify under this term. The study in the Province of Nova Scotia which is mentioned in this brief,

certain studies that have been done on specific programs of various kinds, but these have tended to be fairly limited in the past, partially because the funds for this particular type of purpose have not been available. Secondly, because people who are qualified to do this type of research are at present somewhat limited in numbers.

COMMISSIONER FIRESTONE: Well, this just leads me to the next question. Where would you feel that funds for such a type of research come from, and who would be the people who would be doing the research, and under whose auspices?

DR. HASTINGS: Well, Mr.Chairman, certainly funds could come as at the present time from organizations who wish studies made of programs which they are carrying out. However, this in a sense may have certain implications for the person doing the research, which he may not wish therefore to undertake it. I would feel that certainly certain funds should be made available therefore without strings attached through Government agencies either at the Federal or Provincial level.

As to who might do the research, certainly we have advocated that there should be operational research units within public departments, which would assess their own programs, and beyond this the university, such groups as the schools of hygiene and so on, who are competent to do this, and whose services have been used, might well also expand this type of activity, given the proper support.

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As to who might do the research, certainly, we have recommended that there should be operational research units within public departments, which would assess their own programs, and beyond this the university such groups as the schools of hygiene and so on, who are equipped to do this, and whose services have been used, might well be engaged this type of activity, given the proper support.

COMMISSIONER FIRESTONE: What would you consider a desirable research grant from the Federal Government on an annual basis for these purposes as outlined in Paragraph 58? Would $100,000.00 a year be an adequate amount?

COMMISSIONER FIRESTONE: What would you consider a desirable research grant from the Federal Government on an annual basis for these purposes as outlined in Paragraph 6? Would $300,000.00 a year be an adequate amount?

DR. HASTINGS: Mr. Chairman, I am not prepared to answer that. We made certain comments in this direction as a school, School of Hygiene. I don't feel I am in a position to answer this overall field.

DR. YOUNG: I would think it would be hard to tie down a sum of money, but I would think it would have to be on its merit. We have organized a new service, consultant advisory service, and one of the studies that Dr. Hastings speaks of came about because of that and it was financed by a national health grant, but the amount of money was based on the study. I am certainly not in a position, it would be only a guess, to say the amount of money, overall money.

COMMISSIONER FIRESTONE: You see, this Commission is called upon to make recommendations to the Federal Government. If we are to make recommendations in this field we would like to get advice from a group like your own. Who else can we turn to for advice on the dimensions of a research program in the research field besides the Canadian Public Health Association?

DR. YOUNG: That is No. 4, I guess.

COMMISSIONER FIRESTONE: It is entirely up to you, sir, but it would help us to make these recommendations more specific and we can consider them and be prepared to pass them on.

DR. BROWN: I assume this would be an amount of money that would be continuing?

DR. HASTINGS: Mr. Chairman, I am not prepared to answer that. We made certain comments in this direction as a school, School of Hygiene. I don't feel I am in a position to answer this overall

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Mr. McCUTCHEON: I assume this would be an amount of money that would be continuing?

COMMISSIONER FIRESTONE: Yes. As I understood your paragraph 58, you speak of a continuing research program, and if I read between the lines, you are not thinking of a tied program; you would like to see a research program without having it tied to any one particular program or department?

THE CHAIRMAN: Unless, gentlemen, you feel that paragraph 58 does not lend itself to that and it is essentially a unit proposition in each case, an individual proposition. You, then, don't have so much money for research in this field, for projects on which research should be made, and you are looking for the money.

DR. YOUNG: We would like to play with this and see what we can come up with.

COMMISSIONER FIRESTONE: In paragraph 66, page 17, you say:

"A career service in public health is an urgent need in Canada",

and you outline in the subsequent paragraphs as to why. I am just wondering whether you could be a little helpful to us by indicating specifically what the Federal Government can do to develop or to contribute in achieving what you set out in paragraph 66.

DR. YOUNG: We feel there that the main thing is that people can go freely from the Federal Government to the provincial, to the municipal and back again or university, without losing the beneifts they have built up and without impeding their career. We are thinking possibly of something like the United

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Mr. CHAIRMAN: Gentlemen, you feel that paragraph 58 does not lend itself to that and it is exactly a unit proposition in each case, an individual proposition. You, then, don't have so much money for research in this field, for projects on which research should be made, and you are looking for the money.

Mr. YOUNG: We would like to pay with this and see what we can come up with.

Mr. CHARLES FITZSTONE: In paragraph 56, page 11, you say:

"A career service in public health is an urgent need in Canada",

and you outline in the subsequent paragraph as to why. I am just wondering if you could be a little helpful to us by indicating specifically what the Federal Government can do to develop or to contribute in solving what you set out in paragraph 56.

Mr. YOUNG: We feel there that the main thing is that people can go freely from the Federal Government to the provincial, to the municipal and back again or universally, without losing the benefits they have by it or and without impeding their career. We are thinking possibly of something like the United

States public health service where people have mobility, can go to State jobs and they are also commissioned in special jobs, say, in the forces. The way it is now, wherever you happen to be employed, if you are there for a good many years you can't very well leave actually. I am not too sure of the mechanism by which this can be done, it would have to be a matter worked out between all levels of government so that there would be this easy passage from one place to another, for long-term projects and even for special tasks.

COMMISSIONER FIRESTONE: Are there any arrangements for somebody to move at the present time from the University of Toronto to the Federal Government or vice versa as far as pensions are concerned?

DR. HASTINGS: This, Mr. Chairman, is a problem not peculiar to this field, but the problem of changing jobs in many instances means a loss of seniority, loss of pension benefits, and so on, and our experience has been that this tends to keep people in a position rather than create perhaps a mobility not only in terms of value to the organization but also their own experience.

In this example of the United States public health service mentioned by Dr. Young - is an excellent example in many respects of how this can be achieved, the building up of a very high calibre of people with a very wide experience because there is this mobility possible.

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DR. HASTINGS: They can be seconded to a State position or, in some cases, to a university and then return and they don't lose anything because it is tied to this one central relationship.

COMMISSIONER FIRESTONE: If we were to adopt this or modify this United States system and apply it to Canada, it would apply only in increasing the flexibility and mobility of people at the federal level. I take it your recommendation goes further; you would like to have mobility of all four levels, the three government levels and university level, and perhaps a fifth level, associations like your own.

So perhaps you would even go further than the United States situation?

DR. YOUNG: Yes. That was a good example. We thought, for Canada, a different arrangement might be better. We realize it would be a difficult thing to implement, but we do realize it should be brought forward.

THE CHAIRMAN: Do you know if this subject was canvassed before the Glasgow Commission?

DR. YOUNG: I don't know whether it was or not. I think it likely was becaue our members in the Department of National Health and Welfare have actually contributed much of this material to us, so I would think it probably has been.

COMMISSIONER FIRESTONE: That was a very constructive suggestion, Dr. Young, and we would certainly consider it.

DR. HARTLEY: They can be seconded to a State position or, in some cases, to a university and then return and they don't lose anything because it is tied to this one central relationship.

COMMISSIONER FERGUSON: If we were to adopt this on and by this United States system and apply it to Canada, it would apply only in increasing the flexibility and mobility of people at the federal level. I take it your recommendation goes further; you would like to have mobility of all four levels, the three government levels and university level, and

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COMMISSIONER FERGUSON: That was a very constructive suggestion, Dr. Young, and we would certainly consider it.

I would like to say thank you to you and Dr. Brown and Dr. Hastings for your helpful comments.

COMMISSIONER GIRARD: Mr. Chairman, I have one question.

On page V, the third paragraph, you say that:

"insufficient attention is being given in the basic training of the health professions in prevention and public health procedures."

DR. YOUNG: Well, I think the feeling of our Committee on this, and I think our Association would support it, is that certainly in many places where the health profession get their training, that is all the teachers, at least a great many of the teachers, are more concerned with medical care than they are with prevention and public health, so therefore it naturally follows, when there is only a limited amount of time, that these subjects are apt to not get the attention they should receive, and we feel there is a need for greater emphasis.

I think perhaps Dr. Hastings could speak to that, too, because he is a teacher.

DR. HASTINGS: I am afraid I could not agree with the interpretation placed by Dr. Young on this. The emphasis placed on public health, certainly speaking of our own institution, is a predominant one, and the reference to the field of administration is by comparison relatively minor. I am not sure that that is precisely what he meant.

I would like to say thank you to you and Dr. Brown and Dr. Hastings for your helpful comments.

CONSTITUENT 3 DAVID: Mr. Chairman, I have one question.

On page 7, the third paragraph, you say that:

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DR. YOUNG: I meant in teaching generally of medical students; I didn't mean in the School of Hygiene itself, the people who take courses there. I meant in the teaching of people in the health schools throughout Canada, not the ones that specialize. It would be a sad state of affairs if they didn't put the emphasis on it.

COMMISSIONER GIRARD: I understood you to mean the medical students, nursing students and the health educators, sanitary inspectors.

DR. YOUNG: Yes. That is what I meant.

COMMISSIONER GIRARD: That is what I thought. Now, talking about nursing, I know that in the basic curriculum we try to put in as much as possible of preventive medicine, but there is also the difficulty in getting any kind of an affiliation for the students to not only get this teaching in the classroom but to get it with the Association. It is very difficult to get students in the basic programs, let alone for the nurses taking post-graduate work.

So how much more can we do, how much more can we apply this recommendation to the teaching we are doing now? I don't know about the medical schools, but about nursing.

DR. YOUNG: I really couldn't speak to that.

DR. BROWN: I think, Mr. Chairman, there has been a great deal of development in the field type of work for nurses in training, and there

DR. YOUNG: I meant in teaching generally of medical students; I didn't mean in the School of Hygiene itself, the people who take courses there. I meant in the teaching of people in the health schools throughout Canada, not the ones that specialize. It would be a sad state of affairs if they didn't put the emphasis on it.

COMMISSIONER GRAHAM: I understood you to mean the medical students, nursing students and the health educators, sanitary inspectors.

[illegible] meant.

CHANCELLOR GILADY: That is what I thought. Now, talking about nursing, I know that in the basic curriculum we try to put in as much as possible of preventive medicine, but there is also the difficulty in getting any kind of an affiliation for the students to not only get this teaching in the classroom but to get it with the Association. It is very difficult to get students in the basic programme, let alone for the nurses taking post-graduate work.

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has been enthusiasm to provide this. Here we get health departments involved in their own municipal affairs and we have to point out to them and convince them that it is an advantage to have student nurses visit and have experience in public health services.

COMMISSIONER GIRARD: As a rule you cannot provide this experience before the basic nursing course. We would like to have that and we cannot get it; it is reserved for the students in university taking the diploma in public health nursing. Of course, we do put in the curriculum some teaching on this, but it is only classroom teaching, we can't send the students out in the field to get this experience, they keep it for the students in the university, graduate students in the university.

DR. BROWN: This would mean, Mr. Chairman, literally, that there would have to be on the nursing staff nurses specifically allocated for this purpose only to be able to look after these students.

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DR. KOHN: This would mean, Mr. Chairman, literally, that there would have to be on the nursing staff nurses specifically allocated for this purpose only to be able to look after these students.

Now, the local health department is putting up the funds for it. You get into the situation is it to be or not to be.

COMMISSIONER GIRARD: Maybe it is one of the recommendations you should put in here for the local health department. Thank you very much.

THE CHAIRMAN: Dr. Baltzan.

COMMISSIONER BALTZAN: Gentlemen, I want to express my personal appreciation for the manner of your presentation of the brief. I have had the pleasure to read it. It is stimulating, shows wide interest in many areas. I want to refer to Page 2 where you state, and I quote: "Very great progress has been made in Canada in the health field". Men of authority such as you are, I think it might be possible for you to answer how do we compare in Canada with the so-called well-to-do nationsin relation to progress towards improving the health field?

DR. HASTINGS: Well, Mr. Chairman, within the last year and a half I have had the opportunity of studying the programs in a number of European and other countries in some detail. This question cannot be answered in a categorical fashion. Obviously it depends upon what indices of measurement you are using and what field you are looking at.

COMMISSIONER BALTZAN: I am not interested in plans, but results.

DR. HASTINGS: In some fields. In other fields we are not. For instance, in the field of infant mortality the records of certain other countries

Yes, the local health department is putting up the funds for it. You get into the situation is it to be or not to be.

COMMISSIONER CLARK: Maybe it is one of the recommendations I should put in here for the local health department. Thank you very much.

THE CHAIRMAN: Dr. Palmer.

DR. MARGARET PALMER: Gentlemen, I want to express my personal appreciation for the manner of your presentation of the brief. I have had the pleasure to read it. It is stimulating, shows wide interest in many areas. I want to refer to page 1 where you state, and I quote: "Very real progress has been made in Canada in the health field". Men of authority such as you are, I think it might be possible for you to answer how or we compare in Canada with the so-called well-trodden path of nation to progress towards improving the health reality.

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DR. MARTINEAU: In some fields. In other fields we are not. For instance, in the field of infant mortality the records of certain other countries

of comparable economic stature to our own are better. In other fields in terms of the work going on and in large centres such as Toronto, clinical centres and so on, certainly our work is comparable to that of the best centres elsewhere. It depends what you are looking at, what type of services you are looking at specifically whether it is better or worse. You cannot answer this in an absolute sense the point being we feel it is good but we could improve.

COMMISSIONER BALTZAN: There might be some areas we might be better than others.

DR. HASTINGS: Yes, it is a variable picture.

COMMISSIONER BALTZAN: On the whole we are not terribly behind.

DR. HASTINGS: It depends what you are looking at. The term behind or before could be interpreted many ways.

COMMISSIONER BALTZAN: We had the opposite statement made to us so very often.

DR. HASTINGS: We stand very high among the nations if you are using generalities but we could improve in certain specific areas.

COMMISSIONER BALTZAN: I am very much interested in your repeated theme concerning the positive philosophy towards health. It is a new term and a variation from the previous concentration and in that respect you advocate certain research programs which have to do with public health, but also in this approach to positivie health one must also have research in relation

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DR. HASTINGS: We stand very high among the nations if you are using generalities but we could improve in certain specific areas.

COMMISSIONER MARTRAN: I am very much interested in your repeated theme concerning the positive philosophy towards health. It is a new term and a veneration from the previous concentration and in that respect you advocate certain research programs which have to do with public health, but also in this approach to positive health one must also have research in relation

to the individual's needs for maintaining health. Have we got uniform standards if there is such a thing among humans that is uniform and what may be considered the norms for a healthy person? I have in mind I cannot recall, I have a textbook on anything that shows just how much sleep one has or how much work one may do or even how much fun one may have. Have you in mind in this approach, in this philosophy towards maintaining good health that there must be standards established for the individual?

DR. YOUNG: I think we have that in mind, but as to the lack of indices and so forth we would agree it is hard to define what normal would be but, we would agree with that, that we should strive and have research to find these things out.

COMMISSIONER BALTZAN: We sometimes know more about what is wrong that what is right.

DR. YOUNG: That is true. The alarm bell rings when something is wrong. When you want to prevent it going wrong there is no alarm bell.

THE CHAIRMAN: Make the alarm bell a little more sensitive.

COMMISSIONER BALTZAN: Actually it is almost a question of concentrating the direction from prevention of sickness to concentrating on how to maintain health.

DR. YOUNG: That is right. We feel you should go one step beyond the negation of illness.

COMMISSIONER BALTZAN: Start one step sooner.

to the individual [illegible] maintaining health. Then we get uniform standards [illegible] there is such a thing among humans that is uniform and what may be considered the norms for a healthy person? I have in mind I cannot recall, I have a textbook [illegible] that shows just how much sleep one has [illegible] work one may do or even how much fun one may have. Have you in mind in this approach, in this philosophy towards maintaining good health that there must be standards established for the individual?

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DR. YOUNG: That is true.

COMMISSIONER BALTZAN: There has been so much done insofar as prevention of things and am I right when I think there has been very little done towards that which would provide people with a measure for keeping well? Am I right?

DR. YOUNG: I would think so.

COMMISSIONER BALTZAN: Thank you.

THE CHAIRMAN: As a poor layman I would like to have some explanation of that. I think there isn't too bad a job about keeping us well from day to day public health-wise.

DR. BROWN: Public health services are adequate, doing a good job?

THE CHAIRMAN: They are doing a resonably honest job of it and I wouldn't accept Dr. Baltzan's opinion there is very little done.

COMMISSIONER BALTZAN: I beg your pardon, Mr. Chairman, I said done in relation to prevention. I was stressing the side of direction, instruction, knowledge about norms and the requirements for keeping well rather than preventing sickness. There is a difference. I think you can see that. The approach or philosophy toward positive health as against preventing ill health which you are doing very well in public health, that is acknowledged.

May I now ask a question on Page 3, the last paragraph, "...and therefore recommends that the Royal Commission recognize A, planning is an essential part of the development and administration of health

Dr. YOUNG: That is true.

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May I ask a question on Page 9, the last paragraph. Have the more recommends that the Royal Commission recognize a planning is an essential part of the [illegible] and administrator of health

services in Canada". Have you in mind an organization or a committee to set out formal plans? Is that what you mean, recognize planning as an essential part of the development and administration of health services in Canada?

DR. YOUNG: I think what we are thinking of was a need to have planners, that we are free to plan more the method of planning than having the plan itself. In other words, I think you will agree in many cases the administrator who is doing the planning is so weighed down by administrative detail he cannot stretch himself and do this sort of thing. We are thinking more of the method than we are of any actual plan itself. Perhaps Dr. Brown or Dr. Hastings could speak to that.

DR. HASTINGS: If I could just amplify on that, Mr. Chairman, I think it is the desirability of some type of objective on a long-term basis. What we are endeavouring to achieve for the next 25, 30, 50 years and the desirability of any program that is proposed fitting into the overall rather than on an ad hoc basis. The need arises and we rush into something without thinking it out in terms of implication with existing programs and so forth, in other words, the desirability for some logical approach to long-term thinking in these fields.

COMMISSIONER BALTZAN: A study group as well as the group that has authority to say that is resolved and something should be started now or started two or three years, is that what you are thinking?

DR. HASTINGS: This presumably should be carried out, for example, within various Government

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CHAIRMAN MATTHEW: A study group as well as the group that has authority to say that is resolved and something should be started now or starting two or three years, is that what you are thinking?

Dr. HASTINGS: This presumably should be carried out, for example, within your own Government

departments with responsibility in the health field. It is something that, perhaps, merits some means of tying in voluntary agencies in the professional groups as well on some type of basis so we are not working at cross purposes or hatching a program in private which may get started without adequate thinking-through of what this may mean to our planned program, what we are trying to do in the next thirty years.

COMMISSIONER BALTZAN: Thank you. One last thing on the bottom of the page, we want to be able to compare our country with others and determine the area in Canada with special or particularly acute health problems. My question is, are we fairly well up to date in our health indices or as well up to date as progressive countries? How are we in respect to these health indices?

DR. BROWN: With reference to indices, Mr. Chairman, I think everyone in our field whether in this country or the United States or Great Britain are convinced that we don't have adequate measures or measuring methods in the field of health. It would be desirable that these be developed if that is possible. We know as Dr. Hastings says, in some respects Canada stands very well and in others we don't stand as well, and we must confess we don't actually stand as well as we could. Secondly, studies are being made, are underway at the present time, but there need be many more to determine the yardsticks, methods of measuring indices, as we call them, of the morbidity and our health and ill health experience.

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CONSULTANT BAUTZER: Thank you.

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COMMISSIONER BALTZAN: You have the modus operandi for obtaining the data in relation to these indices in Canada.

DR. BROWN: Well, for example, in morbidity in our Association we believe there is a lot of morbidity information in the records of hospitals and the records of insurance companies and the records of other bodies, but no one is compiling that, analyzing, collating it and coming up with a picture of what our ill-health experience is, because actually we do operate on the basis that we are not suffering from morbidity and mortality is not involved. We are in good health. That is not necessarily true.

THE CHAIRMAN: I might interject here on this matter of indices, our own people get exactly as---- Not perhaps in the same language, but you said here that we were lacking indices from which to make proper projections, and we have had discussions with the Dominion Bureau of Statistics and the Department of National Health and Welfare. We have asked them to get together and make suggestions as to what they would recommend, and what should be done in the line of getting better basic information and indices, from which proper projections could be made, and evaluations of course. We did that back in September.

COMMISSIONER BALTZAN: May I, gentlemen, take it that your motto is that you are sick of sickness?

THE CHAIRMAN: Thank you very much, Dr. Young and gentlemen. We are very grateful to you for your submission and for your attendance here this morning,

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THE CHAIRMAN: Thank you very much, Dr. Young and gentlemen. We are very grateful to you for your submission and for your attendance here this morning,

and your good nature and patience.

DR. YOUNG: Thank you,Mr. Chairman, for listening to us.

THE CHAIRMAN: We will rise until two o'clock.

---Luncheon Adjournment.

/hm

---On resuming at 2:00 p.m.

THE SECRETARY: Mr. Chairman, the first brief this afternoon is from the Ontario Chamber of Commerce. It will be known as exhibit 306, and Mr. Drysdale will introduce his group to the Commission.

---EXHIBIT NO. 306: Submission of the Ontario Chamber of Commerce.

SUBMISSION OF

THE ONTARIO CHAMBER OF COMMERCE

APPEARANCES:

Mr. A.O. Drysdale
Dr. R.M. Anderson
Mr. David Redgrave
Mr. J.T.A. Wilson

MR. DRYSDALE: Mr. Chairman and members of the Commission, it gives me a great deal of pleasure to introduce to you my associates in the Ontario Chamber. On my right is Dr. R.M. Anderson, and on his right Mr. J.T.A. Wilson, and on my left Mr. David Redgrave, our research assistant in the Ontario Chamber.

We certainly have a great deal of pleasure in accepting the opportunity to present on behalf of the Ontario Chamber our views on the health services in the Province of Ontario.

I guess, from what I have been reading in the papers, sir, that you have had any amount of paper presented to you and many briefs to consider. We consider ours relatively simple, and I would just like

---A recessing at 2:00 p.m.

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I guess, from what I have been reading in the papers, sir, that you have had any amount of paper presented to you and many briefs to consider. We approaches this matter very simple, and I would that I be

to have a few opening remarks and then present to you our conclusions.

The Ontario Chamber of Commerce is composed or it is a federation of about 240 boards of trade and chambers of commerce spread across Ontario right from Ottawa, from Atikokan in the north and right through to Niagara Falls in the south. We have approximately in the various chambers 40,000 businessmen and professional people. We have no corporate membership, these boards and the chambers constitute our membership, and we consider them a very good cross-section of the community. We don't stand for any particular segment of the business community; we have farmers, we have industrialists, we have merchants and professional people represented. We have had even members of labour, organized labour in some of the chambers. There are not too many these days; I guess they are mostly withdrawn. But they are certainly free to join.

About 35% of our membership comes from small communities of about 5,000 population or less, as you would expect with a membership of 240.

The Ontario Chamber's main responsibility is to act at the provincial level; we don't give too much direction at the local level. These boards and chambers feel themselves autonomous, and we leave them in that position. But we pursue our main objective in cases such as like we are here today, give our views to boards and commissions appointed by government or directly to government or its agencies.

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We certainly welcome this opportunity because it fits in very well with our way of operating. Occasionally we appoint committees to look into special projects. These committees are composed mostly of our own members; occasionally we do have to bring in people from outside to assist so that we have the technical background for our research. We don't have a large clerical staff; we have a manager, Mr. Redgrave, our research assistant and some stenographical help.

The policy of the Ontario Chamber is set and passed by the members once a year at our annual meeting, which was just completed last month, and each chamber -- board of trade and chamber mean the same; board of trade is a historical name for the Chamber of Commerce -- and at the annual meeting the delegates come prepared to discuss the policies that have been presented. These are set out 60 days in advance to give local boards and chambers an opportunity to discuss it with their membership, and they brief their membership so that when they come to the annual meeting they know what the position is.

As far as in general the Ontario Chamber is concerned, we believe that many things can be done quite effectively by government, and we also believe there are many, many things that can be done quite effectively by private enterprise, and our basic philosophy ---

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MR. DWINNE: Just in terms of your mechanics, was this noted before your general meeting in Niagara Falls?

MR. DRYSDALE: Not as such. I could describe the parts by paragraph. Four of them are covered by that and three others are covered by a similar Canadian chamber. But the main points were all covered at our annual meeting, but not ---

THE CHAIRMAN: Not the document?

MR. DRYSDALE: No. The document has been passed by our Board of Directors. We couldn't meet the deadline, and so it had to be passed and ratified at the annual meeting, but not as a document.

I was going to mention here one of our basic philosophies taken from our policy booklet entitled "Freedom of Enterprise" reads:

"The Chamber believes in an economic "system based on private initiative "and individual enterprise. It believes "that public ownership should be "restricted to fields that cannot be "served efficiently and adequately by "private enterprise and for which "there is a demonstrated and stated "need. The Chamber is opposed to "controls other than these which are "clearly and demonstrably necessary "to protect the public."

So therefore we are not against government doing its part in assisting the needy.

We historically have accepted many social obligations, but feel there must be a demonstrated and stated need before the government should take part.

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Now, perhaps I should explain the reason I am presenting this brief. I am the immediate past-president of the Ontario Chamber, and it was during my term of office that this was prepared and that is why I am presenting it.

If you would refer, ladies and gentlemen to page 2 of our brief.

Summary of Recommendations and Conclusions

a. Responsibility for payment of medical care costs rests primarily with the individual -- part of our policy.

b. There are individuals and families who are unable to budget for their medical expenses, in such cases government assistance is necessary.

c. Existing voluntary plans can be developed further so as to increase their population coverage, extend the range of benefits provided and to eliminate weaknesses arising from enrolment qualifications.

d. A most urgent problem for Canada as a whole in the next two decades will be the supply of an adequate number of physicians, dentists and ancillary personnel.

e. In order to maintain the necessary number of these qualified medical personnel, universities and other centres of medical learning should be encouraged to extend their facilities where possible. New medical and dental schools will be necessary.

f. Bursaries, loans and scholarships should be increased in size and number so as to encourage

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d. A most urgent problem for Canada as a whole in the next two decades will be the supply of an adequate number of physicians, dentists and auxiliary personnel.

e. In order to maintain the necessary number of these qualified medical personnel, universities and other centres of medical learning should be encouraged to extend their facilities where possible. New medical and dental schools will be necessary.

f. Bursaries, loans and scholarships should be increased in size and number so as to encourage

more students to enter medical and dental schools.

g. Added inducement could be provided by amending the Income Tax Act so as to provide higher exemptions for children not qualified for family allowances but who are attending school or university.

h. -- I would like to add a few words that are not in the sheet that you have. The Chamber is opposed to the introduction of a compulsory and universal state medical plan -- "Compulsory and universal" to be placed before "state". Present voluntary plans are capable of extension so as to provide a more complete coverage of population and a wider range of benefits. Efforts by those administering such plans to provide a broader coverage should be encouraged.

I would just like to read the short paragraph under "Preamble". We think this is significant. The principal concern of the Chamber in presenting this brief is the preservation of those economic and social arrangements or institutions which rely upon the self-motivation of individuals for their effectiveness. In doing so, we would like to present two points that are fundamental to our position:

a. that the development of existing voluntary plans could render them adequate to the need to provide protection against unpredictable financial burdens resulting from illness or accident for the greater part of the population;

b. that there are individuals and families who are unable to make provision for the financial responsibilities of health care, either in whole or in part,

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and in these cases, government assistance is necessary.

I think, sir, without going into the supporting data provided, these points cover our feelings with regard to health services in Ontario.

THE CHAIRMAN: Thank ycu, Mr. Drysdale. I have been wondering as you read what significance you put in recommendation (c), use of existing voluntary plans, and then (h) present voluntary plans, and then again on page 3 under a, development of existing voluntary plans. Do you mean that you are opposed to the commercial carriers?

MR. DRYSDALE: No. It would be the commercial carriers, voluntary, as opposed to --

THE CHAIRMAN: So we may get a definition, rightly or wrongly, the voluntary plans become identified with medically-sponsored, P.S.I. and voluntary non-profit plans?

MR. DRYSDALE: No, we would include both types.

THE CHAIRMAN: And the voluntary in that sense is not meant to exclude the insurance companies, the commercial people.

MR. DRYSDALE: That is right.

COMMISSIONER FIRESTONE: Mr. Drysdale, what are the views of the Ontario Chamber of Commerce about the Ontario Hospital Insurance scheme as presently in operation? Are you in favour of that scheme?

MR. DRYSDALE: Well, perhaps the best way to describe that would be that we are not opposed to

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it. We realize that there are certain things that you might say are inevitable, and we are part of this province, we are part of the people in this province, and once a thing is a fait accompli we work with it.

COMMISSIONER FIRESTONE: You speak of certain things being inevitable. I take it is with reference to the health field, because that is the subject we are discussing. What are some of those things you consider are inevitable in the health scheme besides hospital insurance?

MR. DRYSDALE: I don't think I mentioned that the health scheme was inevitable. But there are certain aspects of health that our brief is covering. We believe that there are certain needs, certain groups of people who are unable, for one reason or the other, to look after themselves and look after their families, and we sincerely believe that there is a place for government action in this area.

Perhaps I could ask Dr. Anderson if he would like to enlarge on that point.

DR. ANDERSON: Mr. Chairman, I am not too certain as to what Professor Firestone meant. He asked what were certain things we regard as inevitable.

THE CHAIRMAN: We have obviously death and taxes.

DR. ANDERSON: Yes, this I know.

COMMISSIONER FIRESTONE: I just wanted to know what he meant when he used the word "inevitable".

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MR. DRYSDALE: Historically, I think, when we are dealing with an organization like the Ontario Chamber we believe that we have to be flexible. I don't think there is much use of standing up and waving the flag as we go down on, say, some point like too pure capitalism.

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This is, perhaps, the ultimate, but we know the historically pure capitalism which you might say the Chamber of Commerce many years ago was strongly in favour of, we just don't believe it. We have to be flexible. We have to move with society, but we feel the responsibility to the communities in which our Chambers are located and to the population at large to try and bring out to these people that there is nothing free as far as health plans are concerned. Somebody has to pay.

We want to make sure that before we get involved in these things that the people, you might say, the voter, has an opportunity to see the broad picture, so they know they are not getting something for nothing. Somebody has to pay for it.

At the present time, and I am expressing a personal opinion, I think many people feel that this is free, that they don't have to pay for it and naturally they would take anything that is given free.

We feel we have a responsibility to point this out and we feel private enterprise in certain areas of medical care could do a more effective job, could provide more coverage for less dollars and we feel we could support that. It has been demonstrated, I believe, in some countries. I think that perhaps is a mixture of Ontario policy and personal views.

COMMISSIONER FIRESTONE: To come back to the hospital insurance scheme as it now operates in Ontario, by and large, would you feel that this program has met a need in the Province of Ontario and

[illegible] Chairman, Ladies and Gentlemen:

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Dennis Lewis (Hamilton): To come back to the hospital insurance scheme as it now operates in Ontario, by and large, would you feel that this program has been a drag on the freedom of Ontario and

has the endorsement of the majority of the people of the province as well as members of your Chamber?

DR. ANDERSON: I think the answer could only be in the affirmative.

COMMISSIONER FIRESTONE: Thank you very much. That is helpful to us because the Ontario hospital insurance program has developed certain principles and the question arises whether some of the principles that are already in operation in one sector of the health field are applicable to another sector and whether you would endorse those or you wouldn't.

If I may raise these questions and let you tell us your own thoughts about it. As I understand it, the Ontario hospital plan provides for the financing in part on a payroll deduction plan with employers and employees contributing to the cost of this hospital service for firms of a given size and larger. I am told that covers about 65% approximately of the total cost of the operation.

Then there are about another 30% where people are paying premiums and they achieve coverage in that method and about 5% who, under a voluntary system, are just not covered at all. Therefore, this plan, as it now exists, is a combination of both compulsory features for people employed in companies of a certain size and larger and voluntary features for those that wish to join the plan because it is in their own interest and they don't happen to be employed with these large companies. Therefore, you have a combination of both compulsory and voluntary features.

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CHAIRMAN DUNCAN: Thank you very much. That is helpful to us because the Ontario hospital insurance program has developed certain principles and the question arises whether some of the principles that are already in operation in one sector of the health field are applicable to another sector and whether you would endorse those or you wouldn't.

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Would you feel that a similar combination of features could be applied to a medical care plan?

MR. DRYSDALE: That I would answer negatively. I don't think that necessarily follows because there are two basic differences. Perhaps Dr. Anderson could answer this better, but it seems to me that hospital care is not the same thing as health care where it is a personal - the individual's reponsibility is to look after oneself and you are placed in the hospital, you are placed there by the doctor.

COMMISSIONER FIRESTONE: Are you making a distinction between the method of the individual going to the doctor and the individual being referred by the doctor to the hospital? Is that your distinction?

MR. DRYSDALE: Yes.

COMMISSIONER FIRESTONE: Why do you make that distinction? What is your distinction between going to your doctor and the doctor saying, "I cannot look after you. This is more serious, we had better send you to the hospital" - why do you make this distinction as to the financing of the cost of service?

MR. DRYSDALE: It is more than just financing. When you are considering medical care, I mean that is one aspect of it. There are other things that are involved, the regulations and the control that is impressed on the people involved. By that I mean doctors and patients, which is the basic difference.

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There is quite a difference as I see it as far as the two are concerned. You do not say, "I am going to the hospital." The individual does not say that. Nor does he say, "My child is going to the hospital." It will be the doctor that decides that. That is more or less out of the individual's control. Looking after oneself from a health point of view starts with the individual within the family unit and these things must be voluntary and free. They must have the freedom to choose their own physicians and to go where they feel personally they will get the best treatment.

COMMISSIONER FIRESTONE: Let us assume there is a medical care plan developed that safeguards that freedom of choice of physicians. I think that point is well taken. Let us assume that point is safeguarded. Where do you see the difficulty?

MR. DRYSDALE: Well, I can see many difficulties myself. Perhaps I shouldn't be doing all the talking, but I can see one vast difficulty because you would start like in England where they started on a contributory - it was sold to the population on contributory but in fact it is not any more. The same thing could happen. Once you take that step the next step is gradual erosion; not because the people in charge do not want to do the right thing. It might be political pressure, political expediency and some further steps are taken.

COMMISSIONER FIRESTONE: What are such further steps that you would consider to be detrimental

to the health services provided to the individual citizen assuming the safeguards which you justifiably felt were required continued to be in existence?

MR. DRYSDALE: Here again, Mr. Chairman, I think we of the Chamber and myself in particular, with regard to this, we don't profess, certainly I do not profess, to be an expert on all these things.

Our basic worry is the freedom of the individual and the determination if there is a need. We would like to be absolutely sure that there is a demonstrated need for what you are talking about. You might say it is socially desirable to certain segments of the population. These are expensive affairs and we could very easily spend beyond our means and thereby throttle off the private enterprise section that provides wealth through taxation and find ourselves in a position where we cannot expand. We feel, as I mentioned before, where they are measures by government, they are not sufficient. I am off in an economic field which is your specialty, sir, because, there again, you are provoking a question I am really not in a position to answer.

COMMISSIONER FIRESTONE: You have been very helpful, Mr. Drysdale, and we really are not looking for expert opinion. We really are looking for your own best judgment and that of your colleagues. We are not expecting you to give us a solution of technical problems and we do appreciate your effort to deal with the basic principles involved and give us a little of your philosophy so we can understand more

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Mr. CHAIRMAN: Mr. Dyssart: You have been very helpful, for example, and we really are not looking for expert opinion. We really are looking for your own best judgment and that of your colleagues. We are not asking you to give us a solution of technique. You are, as we do appreciate your effort to date, with the basic training involved and give us a little of your philosophy so we can understand your

of the background of some of the things you have recommended to us.

MR. DRYSDALE: I wondering, perhaps, if some of my associates here would like to discuss that point.

DR. ANDERSON: Mr. Chairman, I have been interested in medical economy for many, many years. I have devoted many hours of my time and thought to all these problems. I am devoted to and I am heartily in favour of the prepayment of medical care so that people can budget for their medical expenses. Having been involved in the provision of such care for people, I don't think I am giving away a secret when I say I was President of P.S.I. for eight-and-a-half years - I know a little bit about the complexities of attempting to cover these needs.

There is no easy solution, sir, as you well know and every time you solve one problem three more pop up. It is like a many-headed Hydra; the more heads you knock off, the more heads appear. I know there is no easy answer to this thing.

Having been aware, as I say, of the complexities of this field, I still am convinced, however, that given a chance, and I know you are going to say, how long do you want for this chance?, but given a chance with the prepaid scheme, the insurance people, I think, will be able to meet reasonably adequately without government intervention or participation except for those people who obviously cannot pay their premium either in full or in part.

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Dr. Appleton: Mr. Chairman, I have been interested in medical economy for many, many years. I have devoted very hours of my time and thousands of dollars of those my less. I am devoted to and I am heartily in favour of the first part of medical care so that people can be sent for their medical expenses. Having been involved in the provision of such care for people, I can claim I am entirely away a secret when I say I was pleasant of it. I too eight-and-half

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Given a chance, I think it can be worked out. We are far ahead, obviously, now, than we were two years ago; witness the effect that has been had on the enrolment of certain communities in this province. You are very familiar with this, I know, and my colleagues in P.S.I. have been before you on this.

As I say, sir, we feel that we can ultimately meet the demands of the people and I know it is a very live demand. I would hate to see it used as a carrot on the end of a stick in front of the voter's nose.

For instance, I am dreading what might happen in this federal election before you people have a chance to digest all the material that has been laid before you in the past months. I hope my fears are unfounded.

You might say, why do you fear government becoming a monopolistic purveyor of medical services? I speak now not as a man of the medical profession because I am no longer in practice and it couldn't matter less to me as an individual what it does but I was a doctor in practice for many years and I went into medicine because I am an individualist. I just cannot make myself come to the point of being told how I am going to handle this patient, how to handle that.

In any kind of scheme, even under the so-called voluntary plans, one of the biggest dangers is control of the type of practice conducted by the men who are working under that system by the administrator

of the plan in order to fit into the pattern of how they are to be paid. That is one of the greatest dangers in the administration of P.S.I. during the years I was on the Board.

I know it goes on at this moment. Constantly we have to remind ourselves we were not there to tell other doctors how to practise medicine. This is the danger, sir, a very serious danger, because you have X dollars to pay for the service or services and because certain physicians do not come into the type of pattern you expect that you could pay for with this operation and you are tempted to reach out and say to this fellow, "This is the way we want you to do this."

This is much more likely to occur in an administration run by the Government on a broad scale, working within budgetary confines. I would think sooner or later, sir, it would be inevitable - I don't like to use the word - sooner or later it would be bound to arise that there must be some constriction on the type of practice being carried out by the men working under that scheme.

As an individual Canadian citizen I am opposed to compulsion. I am very much opposed to being told that I must do this, do that or the other thing providing what I do is something which is not going to affect the general welfare of the community in which I live. Obviously I must be told I cannot drive my car at 95 miles an hour down the road.

But for me to be told that I must engage in this particular type of insurance program, and that if I don't that I can be fined, or that if I am a physician and I am told that unless I provide services according to the dictates of the people who I have elected in parliament, that I am to be put in jail, this sir I cannot contemplate.

COMMISSIONER FIRESTONE: Dr. Anderson, we appreciate your sincere views very much. Just a small question sir. Are you employed with an organization that is required to pay premiums under the hospital insurance scheme in Ontario?

DR. ANDERSON: Yes sir.

COMMISSIONER FIRESTONE: And are you objecting to paying your share?

DR. ANDERSON: I object to the morals of it sir. There are many things I have to do to which I object, and I object to this, not strenuously.

I objected for years for instance being paid a baby bonus. I was mad every time that cheque came in. I am still getting them, which I don't think I need, and I don't think I want, but I still have to take them.

COMMISSIONER FIRESTONE: May I come back to a point which you made a little earlier. I understood you to say, and please correct me if I am wrong, that a government should stay out of things unless and until social needs are clearly established and require government participation. Did I understand you correctly?

Not, sir, is to be told that I must engage in this particular type of insurance program, and that if I don't they I can be fired, or that if I am a physician and I am told that unless I provide insurance according to the wishes of the people who I have elected in parliament, that I am to be put in jail, this sir I cannot countenance.

Chairman: Thank you Mr. Anderson we appreciate your sincere views very much. Just a small question sir. Are you employed with an organization that is willing to pay premiums under the hospital insurance scheme in Ontario?

Mr. ANDERSON: Yes sir.

Mr. CHARLES ARMSTRONG: And are you objecting to paying your share?

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Chairman: Mr. Anderson I want to ask you, which you have a little medicine. I understand you do not, and please correct me if I am wrong, that a government should stay out of things unless and until certain needs are clearly established and require government intervention. And I believe you correctly

MR. DRYSDALE: I used the word a demonstrated and stated need.

COMMISSIONER FIRESTONE: Demonstrated social needs. Was that the phrase you used?

MR. DRYSDALE: That is right.

COMMISSIONER FIRESTONE: We have heard from the Canadian Federation of Agriculture, and a number of labour unions, representing millions of people across Canada, working people, farmers, et cetera, saying there is a social need in Canada, in their opinion, for a State-supported, comprehensive medical care plan on a compulsory basis. This is the judgment of these groups, which is not necessarily a judgment which you share, but how does a government, or a Royal Commission, or any one else advising a government, decide whether social need has been demonstrated or not? These groups feel the need exists. Other groups, like your own, feel there is no need for, as you call it, a compulsory and universal State medical plan in Canada.

How does one formulate the judgment with those conflicting views?

THE CHAIRMAN: By the appointment of a Royal Commission.

MR. DRYSDALE: I would presume that that is really the problem you are confronted with, and that is the nub of the whole thing.

THE CHAIRMAN: I don't think we should put the question in that way to any orgnization, to ask them to come to the conclusions that we must ourselves come to after hearing not only this organization and that

one, but them all, plus our own judgment and evaluation of what we have heard.

COMMISSIONER FIRESTONE: We could get some guidance, at least speaking for myself sir.

You are rather a responsible group, and you have put forward sound views, and any guidance we could get from you would be appreciated.

MR. DRYSDALE: Take my own case. I am employed by the Canada Cement Company. I have P.S.I. and hospitalization. In effect what I pay for physician care on a prepaid medical basis, I don't have to meet any bills unless they are catastrophic.

Now, do I need a State plan, or do any of the employees working at my plant need it? There is not a need in their behalf at all, and we would assume, and there has been evidence, and I am sure that that evidence has been presented to you, that voluntary or private plans give better coverage, more effective coverage, for less money. That is the plan that I have now. I don't need it. There is no stated or demonstrated need in my case, nor in any of the employees at my plant, nor for any of the employees at Dr. Anderson's plants or Mr. Wilson's organization, or for many of those who are employed.

I am not too sure of the percentages. As I say, this is a technical matter, but I believe at least 60% of our population in Ontario have such plans, adequate plans, and Dr. Anderson has mentioned that these can be extended, given a little while to broaden it.

Therefore, to answer your question, I would say that there is no demonstrated need. These people do not need any coverage, but there are areas, I wouldn't argue that there is that outer fringe that are not employed, or who are self-employed perhaps, or unemployed, that do need help, and we recognize that, and we realize that this need must be filled, but for those that are covered and can be covered by private plans there is no demonstrated need.

COMMISSIONER FIRESTONE: Now, Mr. Drysdale, when you speak of those that are in need, I take it that you refer to the group that is generally known as the indigent group and the medically-indigent. Is that correct, or shall I define it for you?

MR. DRYSDALE: Perhaps Dr. Anderson could list them.

DR. ANDERSON: Yes sir, these are the groups we were thinking about.

COMMISSIONER FIRESTONE: In your paragraph 1 (b) on page 2 you say that these individuals and families who are unable to budget for their medical expenses, government assistance is necessary. When you speak of government assistance in this particular case, do you have in mind provincial government assistance, or federal government assistance, or both?

MR. DRYSDALE: Well, I would imagine it would be both. In some cases it is even at the third level of government, but it is some government body, and I should think with our income tax set-up that it would be a shared basis one way or the other, municipal

Therefore, to answer your question, I would say that there is no demonstrated need. These people do not need any coverage, but there are areas, I wouldn't argue that there is that outer fringe that are not employed, or who are self-employed perhaps, or moreover, that do need help, and we recognize that, and we realize that this need must be filled, but for those that are covered and can be covered by private [illegible] there is no demonstrated need.

Senator, when you speak of those that are in need, - take it that [illegible] or to the group that is generally known as the underprivileged and the medically-indigent, is that correct, or shall I define it for you?

[illegible] perhaps Dr. Ambrose could [illegible] them.

[illegible] Yes sir, these are the people we are trying to talk about.

[illegible] In your paragraph 1 (b) on page 5 you say that these individuals and families who are unable to budget for their medical expenses, government assistance is necessary. When you speak of government assistance in this particular case, do you mean in kind from municipal government as a [illegible] or [illegible], or both?

[illegible] Well, I would imagine it would be both. In some cases it is even at the third level of government, but it is some government body. [illegible] I should [illegible] to say that it would be a shared [illegible] on the other, medicine

and provincial, or provincial and federal.

COMMISSIONER FIRESTONE: Well, you elaborate a little on this point on page 11 in paragraphs 30 and 31. You mention in paragraph 30 a group which we generally understand to be included in the category of the indigent. Now, I understood from Dr. Anderson that you really had in mind a broader coverage than that that is indicated in paragraph 30, to include also the medically indigent, who are people not on the welfare lists, or covered under the direct welfare legislation?

MR. DRYSDALE: Well, these are not all indigents here. That is a technical matter I am not familiar with sir.

COMMISSIONER FIRESTONE: Just to have Dr. Anderson's understanding. As I understood it from you sir, you would really go further than the coverage in paragraph 30, to cover also the medically indigent, who are people who may at times be able to look after themselves, but then become unemployed and are not covered in this paragraph 30, but would still be eligible under the plan which you support?

DR. ANDERSON: Yes sir.

COMMISSIONER FIRESTONE: You are only talking in paragraph 30 of the provision for medical care services for this group, plus the medically indigent group that we are talking about. Now, would you feel that perhaps coverage should be extended to cover comprehensive health care services, rather than limited to medical care only?

and provincial, or provincial and federal

[illegible] [illegible]. Well, you elaborate a little on this point or page it in paragraphs 20 and 21. You mention in paragraph 20 a group which we normally understand to be included in the category

that you really had in mind a broader coverage than that that is indicated in paragraph 20, to include also the medically indigent, who are people not on the welfare lists, or covered under the direct welfare

MR. MACSHAN: Well, these are not all indigents here. This is a technical matter I am not familiar with.

MEDICALLY INDIGENT: Just to have in Hansard understanding. As I understood it from you also, you would agree, rightly so then the coverage in paragraph 20, to cover also the medically indigent, who are people who may at times be able to look after themselves, but then become unemployed and are not covered in the [illegible], you would still be eligible under the plan which you suggest?

[illegible]

only taking in [illegible] the [illegible] for medical care [illegible] for [illegible] the medically indigent [illegible] do [illegible] to [illegible]. Well, you know that [illegible] should be [illegible] to [illegible] [illegible] [illegible] [illegible], [illegible] [illegible] [illegible] [illegible]

DR. ANDERSON: Mr. Chairman, yes. This is certainly my feeling, that people in the indigent or para-indigent group should be offered a comprehensive coverage.

COMMISSIONER FIRESTONE: And by comprehensive coverage you would include besides medical care services such things as drugs, dental care, nursing care of a special character?

DR. ANDERSON: In my thinking this is comprehensive care.

COMMISSIONER FIRESTONE: That is a very constructive answer. My last question is, assuming that such more comprehensive services are made available in the Province of Ontario, covering more people than are covered at the present time, and I may draw your attention to the proposal which the Ontario Medical Association has made to the Ontario Government to extend coverage to this particular area. If such a plan were developed it would cost more money. Would the Ontario Chamber of Commerce support increased taxes to pay for those expanded health care services for the needy?

MR. DRYSDALE: Yes, we would. After all, if we accept it I think we have to be prepared to pay for it, and just how that might be done is another question. In other words, depending upon who you extract the money to do this.

COMMISSIONER FIRESTONE: Let's call this a technical question which I will not address to you, so long as you are in support of the principle.

A MEMBER OF THE PUBLIC: Can a question

This is certainly my feeling, that people in the rich part of Canada should be offered a comprehensive coverage.

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DR. [illegible]: Yes, we would. After all, if we accept it I think we have to be prepared to pay for it, and that is that must be done in another direction. In other words, something upon who you account the money to do this.

COMMISSIONER FIRESTONE: Let's call this a hypothetical account on which I will not address to you, so long as you are in support of the principle.

A MEMBER OF THE PUBLIC: Can a question

be asked from the floor?

THE CHAIRMAN: It depends who you are and what you want to question about.

A MEMBER OF THE PUBLIC: My name is David Gray. I represent some citizens who have some further interest in this affair. Is it possible ---

THE CHAIRMAN: Excuse me, I understand you are with the C.B.C.?

MR. GRAY: I am under contract with them at the moment.

THE CHAIRMAN: Well, if you are coming in here as a representative of a news media to ask questions, the answer is no.

MR. GRAY: Does that go into the record, that we are not allowed to ask a very basic question?

THE CHAIRMAN: It is not a question of you not being allowed to ask, but this Commission is not sitting to provide a place for the C.B.C., or a newspaper, or any other news media, to draw their information that way. Had you told me, had you been frank about it when you stood up ---

MR. GRAY: I had already called Mr. Lafrance.

THE CHAIRMAN: Had you been frank about it, I would have said ---

MR. GRAY: Is it not possible for an individual, an individual Canadian citizen, to make any kind of representation to this Commission?

THE CHAIRMAN: You know that that is

be asked from the floor?

THE CHAIRMAN: It depends who you are and what you want to ask on about.

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THE CHAIRMAN: It is not a question of you not being allowed to ask, but this Commission is not sitting to provide a place for the C.B.C., or a newspaper, or any other news media, to draw their information that way. Had you told me, had you been frank about it when you stood up ---

MR. GRAY: I had absolutely no, LaFrance.

THE CHAIRMAN: Did you not frank about it. I would have said ---

MR. GRAY: I do not represent for an individual, an injured individual, to make our stand if necessary, in more formal.

THE CHAIRMAN: You know that that is

not true. There has been a general advertisement carried in the news media of this country. Don't start brow-beating here, even from any pedestal, whatever the news medium may claim to be, but since you suggest the individuals cannot be heard, I just wanted to tell you that they can. This Commission advertised in the news media of Canada in all ten provinces that individuals would be heard.

MR. GRAY: If they got 25 copies, and could afford to give 25 copies to the Commission in time.

THE CHAIRMAN: And if you will look at the program that we have here, there are many individuals who are going to be heard at this hearing.

MR. GRAY: If they can afford the price.

THE CHAIRMAN: And when those who have signified their intention, and politeness ought to be a component of anyone in the news media, and if there is anyone who wishes to put a question when all those who have already signified their intention of appearing have had a chance to appear, they will also be heard, but we will not interrupt the proceedings.

MR. GRAY: I apologize, Mr. Commissioner.

THE CHAIRMAN: We will not interrupt the proceedings in this way, merely to accommodate somebody who may have some reason or another to put a question at a particular time to suit himself.

MR. GRAY: I am sorry sir.

THE CHAIRMAN: Thank you Mr. Drysdale. We are very grateful to the Chamber of Commerce for this submission. You appreciate as well as we do that

we are obtaining divergent views from various people who are here before us, and as I mentioned it is our responsibility in the end to make such recommendations as we may see fit to do, and we are assisted by all who appear here before us, because it is only by having the views of all that we may have some expectation of coming to a right conclusion.

MR. DRYSDALE: Thank you very much sir.

THE SECRETARY: Mr. Chairman, the next submission is that of the Canadian Association of Health, Physical Education and Recreation, which will be known as exhibit 307, and Mr. Speirs will introduce his group.

---EXHIBIT NO. 307: Submission of the Canadian Association of Health, Physical Education and Recreation.

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Thank you very much.

MR. CHAIRMAN: Mr. Chairman, the next submission is that of the Canadian Association of Health, Physical Education and Recreation, which will be known as exhibit 37, and Mr. Lewis will introduce his group.

EXHIBIT NO. 37: Submission of the Canadian Association of Health, Physical Education and

L/ss

S U B M I S S I O N O F

THE CANADIAN ASSOCIATION OF HEALTH, PHYSICAL EDUCATION AND RECREATION

APPEARANCES:

MR. N.R.SPEIRS
PROF. J. LIFE
MR. G.A. WRIGHT
PROF. KIRK WIPPER
MR. C.R. BLACKSTOCK
MISS E.B. SEXTON

MR. SPEIRS: Mr. Chairmana, my name is Speirs, I am the Vice-President of the Canadian Association of Health, Physical Education and Recreation. In real life I am the director of Physical Education for the Toronto Board of Education, which may account for the error in the agenda attributing this brief to that organization. This is the Canadian Association of Health, Physical Education and Recreation. On my extreme right is Miss Sexton, a private member of this Association who inspects the girls' physical recreation for Ontario secondary schools. Next is Mr. C.R. Blackstock, our Executive Secretary, also National Director for Water Safety of the Canadian Red Cross Society. On my extreme left is Mr. Kirk Wipper, Assistant Professor of the University of Toronto School of Physical Health and Education under the directorship of Dr. Harry Ebbs. He is also a member of a private camp for boys, Camp Candelon. On his right is Mr. G.A. Wright of our Association and also a director of the Ontario Branch; and Mr. Jack Life, Editor of our journal and also on the staff of

[illegible]

[illegible]
[illegible]
[illegible]

[illegible] Mr. Chairman, my ma-
in theme, I am the vice-president of the Canadian Associa-
tion of Health, Physical Education and Recreation. In
real life I am the director of Physical Education for
the Toronto Board of Education, which may account for
the error in the usual attitude, this brief to that
organization. This is the national association for health,
physical education and recreation. On my extreme right
is Miss Saxton, a private member of this association who
represents the national physical education for Canadian
secondary schools. Next to Mr. Fitz-Gerald, our
executive Secretary, also national director for [illegible]
[illegible] of the Canadian Legion. On my extreme
left is Mrs. Alice Jones, Assistant Inspector of the
University of Toronto School of Physical Education and
Education during the time [illegible] it is, early [illegible]. It
is also a member of a private [illegible] for boys, [illegible]
[illegible]. In this right is Mr. [illegible] Mr. [illegible] of our Association
[illegible] also a director of the Toronto Parks, and Mr.
Jack [illegible], [illegible] of our [illegible] and also on the staff of

the Ontario College, Physical Education Department.

I believe you have copies of our brief which contains a statement outlining information about our Association.

At this time I would like to read the preamble and then ask a member of our panel to read the recommendations.

Romain Rolland's book about Mahatma Gandhi gives three reasons why he did not covet Western Civilization for India - our attitudes towards law, health and education.

According to Gandhi, Western Medicine was oriented towards the relief of symptoms - palliative treatments - which enabled people to violate the rules of health and escape (or at least postpone) the consequences. This, he said, demoralizes people. It weakens their will power by helping them to cure themselves with Black Magic prescriptions instead of observing healthy ways of living.

D.r Arthur Steinhaus pokes fun at drug store health merely by assembling advertising claims.

Advertisers advise you to:

Wake up with Caffeine
Keep going on Nicotine
Move bowels on Serutan
Kill pain with Aspirin
Stay alive on Geritol
Drown worries in Alcohol
Adjust your stomach on Tums
Lift your arches with Steel
Hold your belly with a Three-Way-Stretch

[illegible] speaks [illegible]

the Ontario College, Department of Education Department.

I believe you have copies of our brief which contains a statement outlining information about our Association.

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Mahatma Gandhi's book about Mahatma Gandhi gives three reasons why he did not novel [illegible] civilization for India - our attitude towards law, health and education.

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Dr. Arthur Hartshorne takes him at drug stores health merely by accepting advertisements, [illegible] [illegible] advertisers, advise you to:

[illegible] with [illegible]

[illegible] pains on [illegible]

[illegible] on [illegible]

[illegible] with [illegible]

[illegible] on [illegible]

[illegible] works in [illegible]

[illegible] your [illegible] on [illegible]

[illegible] [illegible] [illegible]

[illegible] daily with a [illegible]-

Write exams on Benzedrine

Quiet tensions with Tranquilizers

Dispel nagging backache with Kidney Pills

Go to sleep on Barbiturates

Start the day with bubbling Alkalizers
to get rid of yesterday's brown taste
and make room for today's brown taste.

"Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" states the Preamble to the Constitution of the World Health Organization.

And Yet, if one may judge by the press reports, most of the submissions to this Commission so far have shown this bias or pre-occupation with disease.

There has been much talk about Health Insurance. Is that what we really want? What we think of as health insurance is really SICKNESS INSURANCE.

How much health education goes on in a doctor's office, or in our hospitals?

The cost of proposals so far set before this Commission must add up to a sum dangerously approximating the gross national product, and this is only the half-way mark. There are still seventy-one more briefs to be heard in Toronto. Is it not remarkable that so many of these proposals deal with medical treatment rather than prevention of ill-health by positive means?

It is the modest intention of this brief to draw attention to some positive aspects of health which we believe should have more attention from those responsible for providing Health Services.

Ideas

[illegible]

[illegible] tenders with Tuberculosis

Paper supply backlogs with Midway

Go to sleep on Jail inmates

Last the day with [illegible] Airplanes
to get rid of yesterday's brown taste
and make room for today's brown taste

"Health is a state of complete physical, mental
and social well-being and not merely the absence of disease
or infirmity" stated the Preamble to the Constitution
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There has been much talk about health
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of as health insurance is really SICKNESS INSURANCE.

How much of the education goes on in
[illegible] or in our hospitals?

The cost of proposals so far set before
this Commission must add up to a sum dangerously approx-
imating the gross national product, and this is only the
beginning [illegible] more health
to be bought in [illegible] that [illegible] so
many of these problems deal with medical treatment rather
than prevention of illness by positive measures.

It is [illegible] information at least
brief to draw attention to more positive aspects of health
which we believe such [illegible] attention from those
responsible for [illegible]

The aspects we would have you consider are comprised under the term Physical and Health Education - and consist of measures which are conducive to "the good life" rather than the self-indulgent life.

Perhaps this is Russia's real secret weapon. Much publicity has been directed towards the emphasis placed on advanced science and maths in Soviet schools, but not everyone has noticed the lavish provisions for Physical and Health Education at all levels.

We covet for Canada a nation of robust, game-loving people.

We warn against the danger of becoming a nation of neurotic, pill-swallowers.

Mr. Chairman, do you wish us to comment on the individual resolutions or shall we rely on the Commissioners to draw us out with questions?

THE CHAIRMAN: Well, I think if you wish to expand anything now, you should take the opportunity, because questions might not be forthcoming which would deal with the subjects you want to deal with.

MR. SPEIRS: We are prepared to do it either way.

THE CHAIRMAN: Whichever way you wish to do it. We are here to listen to you primarily.

MR. SPEIRS: Then I will call on Prof. Life to comment on resolution number one, which reads as follows:

1. It is recommended that the Royal Commission on Health Services stress the importance of Physical Education, Health Education and

"public

We asks, if we would have you consider
are comprised under the term "physical and health education"
and consist of courses which are conducive to "the good

"employ this in Russia's real sphere
Much publicity has been directed towards the
academic dance on advanced science and ballet
schools, but not everyone is noticed the lavish pro-
visions for physical and health education at all levels.
We never for Russia a nation of robust,
game-loving people
as were confident the danger of becoming
a nation of neurotic, self-conscious.
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commissioners to carry us out with questions?
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because questions might not be forthcoming which would deal
with the subject you want to deal with
[illegible] are prepared to do it
either way.
[illegible] whichever way you wish
[illegible] we are [illegible] to your particular
[illegible] then I will call on
[illegible] to [illegible] resolution number one, with
[illegible] letters
It is [illegible] that the [illegible]
[illegible] activities [illegible] the [illegible]
[illegible] conditions, [illegible] [illegible]

Recreation in the total Canadian health picture, particularly the contribution that they make to good physical health and the prevention of disease through sound Health Education.

PROF. LIFE: WLll, Mr. Chairman, ladies and gentlemen, we believe, and we think are backed-up by the medical profession in this belief, that the major health problems today center around the problems which have something to do with the way we live. For example, cardiovascular disease seems, according to research of the medical profession, to be a functional disease; that is we are living in such a way that perhaps we are a little more susceptible to this sort of thing. Mental illness is probably the greatest health problem we have today; cancer, of course, another great problem, and we think one which isn't usually mentioned under a health problem and that is the problem of accidents is pretty important in our society today. These things we think are partly, and I stress the word "partly", caused by the way we live. We live in a society which has become more and more sedentary and we believe perhaps more physical activity of a recreational nature may help to prevent some of this situation. We are backed-up in what we say by experts, particularly experts in the fields of cardiovascular disease and mental health. For example, Dr. Jack Griffin, General Director of the Hygiene Council of Canada, spoke to our convention, our Canadian Association convention last June, and he was very hopeful that the kind of things that we propose, that is physical

[illegible]

[illegible] in the total Canadian health [illegible], [illegible] the conviction that they make [illegible] physical health and the [illegible] of disease through sound health [illegible]

[illegible] are [illegible], we [illegible], and we that are backed-up by the [illegible] profession in this belief, that the nation health problems today [illegible] around the problems which have something to do with the way we live. The [illegible] research [illegible] to be a functional disease. [illegible] we live living [illegible] a way that permits [illegible] a little [illegible] to this sort of thing, [illegible] [illegible] the greatest health problem we have today [illegible], of course, another great problem, and we think our [illegible] health [illegible] restricted under a health problem [illegible] or accidents is another important [illegible] today. These things we think are [illegible], and [illegible] "health", caused by the way [illegible] in a society which has become [illegible] [illegible] believe people's [illegible] [illegible] national [illegible] may help to prevent some of [illegible]. As the Dominion in [illegible] by [illegible], industry [illegible] the field of [illegible] [illegible] [illegible] [illegible] [illegible], [illegible] [illegible] of the Dominion Council of [illegible], [illegible] to the [illegible], [illegible] [illegible] [illegible] [illegible], as we [illegible] [illegible] that the [illegible] of [illegible] the [illegible], that is [illegible]

activity through enjoyable recreation, school programs, etcetera, could be very helpful in relieving tension and relieving situations which perhaps contribute to mental ill-health.

I could give you a lot of quotations from Dr. Griffin, Dr. J. B. Wolfe of the United States, and so on. I don't think these are necessary. I think it is proven fact by these people, these experts in the field. A doctor Hans Salye, the endocrinist from Montreal, himself carries out a very vigorous program of physical activity daily as a means of helping himself to keep in a healthy state. We think this is prevention rather than correction, this is prevention of health problems.

In terms of cardiovascular disease I think I could just mention one eminent man, and that is Dr. Paul Dudley White who we heard speak at the health forum in March. He feels, at least he said that the most important factor in preventing arthrosclerosis, which he feels is the greatest health problem today, the problems of arteries, is physical exercise, and he doesn't go overboard, he doesn't feel everybody should do physical jerks every day; people should do physical activity which is going to help prevent this illness, which, as he says, is a far greater problem than actual heart illness or heart disease itself. But he feels the great problem we have is diseases of the arteries.

With regard to this first resolution, we will feel we have a contribution we can make, and this is particularly in terms of schools, with which we are very

activity [illegible] parents' permission, school [illegible], [illegible] etc., could be very helpful [illegible] relieving tension [illegible] relieving situations which perhaps contribute to [illegible] ill-health.

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In terms of [illegible] disease I think I could [illegible] one [illegible], and that is Dr. Paul Dudley White who I heard speak at the [illegible] forum in [illegible], and he said that the most important factor in [illegible] arteriosclerosis, which he feels is the greatest health problem today, the problems of arteries, [illegible], and [illegible] over-[illegible], he doesn't feel [illegible] physical fitness [illegible]; [illegible] activity [illegible] going [illegible], as he says, is [illegible] good [illegible]. [illegible] the great [illegible] we [illegible].

[illegible],

we [illegible] feel [illegible] we can make, and this [illegible]

much concerned, and that is the area of health knowledge, health education, which in Ontario has fallen to our universities, to be able to conduct some health education with pupils. We realize that this is subject to some criticism by certain people.

much concerns, and that is the area of health knowledge, health education, which in Ontario has fallen to our universities, to be able to conduct some health education with pupils. We realize that this is subject to some criticism by certain people.

pw

By and large, it could be a very helpful thing if it is started. We feel, perhaps, this Commission might be able to make recommendations which would support this dissemination of health education through the schools. We have found in some parts of Canada, health education is being taught by people who really have no, very little, background, shall I say, in actual medical facts, if we could call it that.

For instance, English teachers teach this subject, probably very capable people but hardly qualified to teach people how to be healthy. So, we feel, perhaps, through getting this knowledge to young people, particularly in the areas of immunization, the value of immunization and so on, let's get this premise of prevention of disease going, keep it always in the public eye in terms of health practice, in terms of accident prevention.

I think probably the best example we have of accident prevention through education is Elmer the Elephant which we see flying over most schools, certainly in the metropolitan area. Elmer the Elephant was introduced a number of years ago as a symbol of an accident-free school and through this educational program, in using the system of Elmer the Elephant, there has been a tremendous reduction in the number of accidents to schoolchildren in the metropolitan Toronto area. This is health education. This is positive health education.

THE CHAIRMAN: Apparently you are able

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[illegible] a [illegible] [illegible] are also

to teach children better than adults.

PROF. LIFE: That is true; if we can start preventive measures early I think we can do something valuable. We are thinking in terms of cancer, lung cancer, education of children with regard to tobacco and, incidentally, alcohol and so on so that they will make intelligent decisions with regard to this whole problem of should I smoke or shouldn't I smoke, before the habit has become ingrained as it is in many of us.

We can perhaps put the facts before them as has been done in the schools for many years and let them make intelligent decisions and not decisions based on someone telling them, "You shalt not smoke"; decisions based upon information, actual information which is true factual information of a professional nature and these pupils can then, these young, intelligent people, can make their decision.

I think we feel our profession can make a contribution here. We feel that this Commission, perhaps, should be thinking in terms of prevention. It is a positive approach to health. Consequently, we make this first recommendation.

THE CHAIRMAN: Thank you very much.

MR. SPEIRS: Not to worry this too much but it is better to prepare than repair. I would like to now call on Mr. Blackstock, who has to leave us shortly for London, to talk about recommendations in the way of professional people who carry on these programs which are resolutions 2 and 3.

to teach children better than results.

[illegible]: That is true; if we can start preventive measures early I think we can do something valuable. We are thinking in terms of cancer, lung cancer, education of children with regard to tobacco and, incidentally, alcohol and so on so that they will make intelligent decisions with regard to this whole problem of should I smoke or shouldn't I smoke, before the habit is become ingrained as it is in many of us.

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I think we [illegible] our profession can [illegible] perhaps, should be concerned in terms of prevention. It is a positive approach to health. Consequently, we make this first recommendation.

[illegible]: Thank you very much.

[illegible]: Not to worry this too much but it is easier to prevent than repair. I would like to ask [illegible] Mr. [illegible], who I see to have an specialty for lunches, to talk about recommendations in the way of professional people who carry on these procedures in the [illegible] and [illegible].

MR. BLACKSTOCK: Sir, Miss Girard, gentlemen, our Association is not so presumptuous as to suggest that you are not able to call on such a consultant as is recommended in Recommendation 2, but we would like you to know the Association is prepared to co-operate with the Commission and to produce a person or persons from whom you might choose if you so desired to have a consultant.

We think it is important enough, the contribution of people in health education, physical education and recreation, is important enough for the Commission to draw upon those who are well-trained for the fields and who are well-experienced in them.

We present this recommendation for your consideration and we do it with help in mind rather than making it a mandatory matter.

In Recommendation 3 we know that others who have preceded us before your Commission have made this recommendation and that suggestions and actual arrangements have been made to facilitate this support for students who might enter one of these three fields.

There is a very definite need for more of these people. The Association is doing as much as it can at the present time and hopes to be able to do more to encourage or to recruit students to the schools of physical and health education and recreation who will serve our citizens of the future. Those are my comments, sir.

THE CHAIRMAN: Thank you very much.

[illegible] MR. [illegible]: Sir, Miss Howard,

[illegible], our education is more or presentations as

to [illegible] that you are [illegible] to call on [illegible]

consultant [illegible] recommended in Recommendation 1, but

we would like you to know the Association is prepared

to co-operate with the Commission and to produce a

person or persons from whom you might choose if you

so indicated it have a consultant.

I think it is important enough, the

contribution of people in the 17th century, political

education and reformation, is important enough for the

Commission to draw upon those who are well-trained for

the [illegible] and who are well-[illegible] in them.

We present this recommendation for

your consideration and we do it with [illegible] in mind

rather than [illegible] in a mandatory manner.

In conclusion, we hope that

others who have preceded us before this Commission

have made this recommendation and that suggestions

and actual commitments have been made to facilitate

this support for [illegible] in [illegible] one of these

[illegible]

[illegible] is a very [illegible] not for

[illegible] of these people. The Association is doing as much

as it can [illegible] and hopes to be able to

do more [illegible] to [illegible] students to the

[illegible] and [illegible] education and [illegible]

and [illegible] the future. We are

[illegible].

MR. [illegible]: Thank you very much.

MR. SPEIRS: I am going to take the liberty, if I may, to ask you to turn to No. 8, which seems to follow logically at this point and get Miss Sexton off the hook; she says she is nervous.

MISS SEXTON: You shouldn't tell on me. I am trying to hide it. Ladies and gentlemen, as Mr. Speirs said, I wish to draw your attention to No. 8, and may I read it?

"Financial assistance is needed to conduct emergency programs immediately in teacher training for secondary school women teachers of physical education to relieve the appalling shortage in the area."

I would like to say that the extent to which our professional physical education can contribute to physical and mental health is certainly almost totally dependent on adequately trained teachers and personnel in general.

I would like to draw your attention to the sheet, I think it was given to you, which is simply pointing up this need in the schools. It is entitled Women Teachers of Physical Education, Secondary Schools. There are two parts to this.

The top half has to do with the schools themselves and the lower half with teachers. I would like to point out the information here is exclusive of the large areas in the province which include metropolitan Toronto, Hamilton and so forth and Windsor. The other aspects of the province are listed.

[illegible] 11.20

MR. SMITHES: I am going to take the liberty, if I may, to ask you to turn to No. 8, which seems to follow, and only at this point and get this taken off the book; she says she is nervous.

[illegible]

me: I am trying to hurt it. Ladies and gentlemen, as Mr. Smith said, I wish to draw your attention to [illegible]

"Financial assistance is needed to [illegible]

in [illegible] ing for secondary school women teachers of physical education to develop the coaching skills in the [illegible]."

I would like to say that the extent to which our provincial physical education can contribute to physical and mental health is certainly almost totally dependent on adequately trained teachers and [illegible] to do that.

[illegible] sheet, I think it has given to you which is simply [illegible] the [illegible] in the schools. It is entitled Some Aspects of Physical Education Secondary Schools. [illegible] to [illegible].

[illegible] case is [illegible] schools [illegible] and the [illegible] with [illegible] [illegible] I like to [illegible] the [illegible] in here is [illegible] of the [illegible] to [illegible] [illegible] [illegible]. Nutrition and [illegible] and [illegible]. The other [illegible] the [illegible] are [illegible].

On the west, St. Clair in the western end of the province with 22 schools in the whole area, secondary schools and 15 of the 22 schools have no teacher who holds a certificate for teaching physical education. 68% of the schools in the area have not got a qualified teacher. That was probably in the middle. The area hit hardest, of course, is the North Western, one city of which would be Fort William. There are 32 schools in this area and 26 of the 32, that is 81% of those schools, have no qualified teacher of health and physical education.

No. 6 is the central part of the province, 30 schools. That would be in the area near to Toronto and out of the 30 schools 10 schools have no certified teacher of physical education, 33.1/3%. It seems to work out from the centre, that the qualified teachers are around the larger areas and the further out you go to the North Western and Ottawa and Windsor areas, and there are more and more unqualified teachers.

At the bottom, 55% of the total schools do not have a qualified teacher.

As I said, this excludes metropolitan Toronto. Actually, I don't think if we had put in those areas, those five large urban areas, it would have made much difference.

Last year, in the City of Toronto, one-third of the women teaching physical education in secondary schools did not have a certificate to do so and were on what we call a Letter of Permission. This is just the other side of the same picture at the foot

[illegible] the west, in Cleveland to western end of the province with 27 schools in the wholly rural secondary school areas, in 9 of the 2 schools have no teachers who possess a certificate for teaching purposes, education. Every of the schools in the area have not got a qualified teacher. This was probably in the middle. The area has its largest of course, is the Toronto metropolis, one city of which [illegible] in the East William-Hope are 21 schools in this area that is 9 of the 22 that is 81% of these schools, have no qualified teacher of [illegible] and physical education.

So it is the central area of the province, 9 schools. That would be in the area near to Toronto and out of the 15 schools 10 schools have no certified teachers of physical education, 73.1/3%. It seems to work out from the centre, that the qualified teachers are around the large areas and the further out you go in the North Western and Ottawa and [illegible] areas, and there are more and more unqualified teachers. [illegible] the [illegible] 55% of the total schools in [illegible] do not have a qualified teacher.

[illegible] is hard. This [illegible] means that [illegible] doesn't [illegible] if we had not in [illegible] the [illegible] across, it would have been [illegible] difference.

[illegible]

One-[illegible] the [illegible] in [illegible] administration in [illegible] schools [illegible] have [illegible] and [illegible] a [illegible] at [illegible]. This is [illegible] the [illegible] of the [illegible] of the [illegible]

of the page, the teachers themselves. There are more teachers, of course, than schools because some schools have more than one teacher. The total number of teachers is 470.

Almost all the schools, not including the large areas, have 68% total teachers unqualified. The total number without even a university degree is 21%. That is the situation. That is the need.

We feel the recommendation for something to alleviate this need would be an emergency training plan to prepare teachers, at least in part, for teaching physical education and health in the secondary schools.

You will note we have 21% of the teachers that do not have a university degree. In an emergency training plan it would probably be a two-year course which would include both academic and physical health education. Of course, staff would be necessary for such schools. Where are we to get the staff? It is like a vicious circle. I think they would have to be lured from the areas that already have teachers and how are we going to pay them? They would certainly have to be paid at least as much as they are already receiving.

I am not going to attempt to say how many, how large a staff it would need. It would depend on the number of people in the course. I would assume, if you could get any teachers who would be capable of the job, they would take not less than $10,000 per annum.

These are our suggestions and an attempt

of the year, in the [illegible] classrooms. There are some
teachers, of course, that [illegible] be more. One should
have more than one teacher. The total number of teachers
is 420.

[illegible] the schools, not including
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[illegible]
[illegible], how [illegible] [illegible]
[illegible] the [illegible] [illegible]. I would
[illegible] [illegible] would be
[illegible] the [illegible] [illegible]
[illegible]

[illegible] structure and [illegible]

at clarifying the need and the remedial possibility.

THE CHAIRMAN: Thank you very much. Without the slightest indication of nervousness.

MR. SPEIRS: May I call on Professor Wipper to talk about our need in terms of research and evaluation.

PROF. WIPPER: Mr. Chairman, lady and gentlemen, I will be very brief on this matter of research and evaluation. I think both are implied in the term "research". Certainly it can be argued there is a great deal of research accomplished in the United States and England. It can also be argued, perhaps, this data could be used in our country, but I believe that the kind of research and evaluation we need must be done here and related to our problems under the conditions we have in Canada.

In that area we have very little accomplished. There is a great need to test the kind of health education our children need. People can do this, get what knowledge they have and what application to habits of life. This knowledge is a matter generally in the area of research and evaluation. Our plea would be to support the matter of research and evaluation in Canada for Canadians by Canadians.

THE CHAIRMAN: Thank you very much, Professor Wipper.

MR. SPEIRS: Mr. Wright will explore the inequality of health services in schools.

MR. WRIGHT: I, too, will be very brief. Mr. Chairman and Commissioners, the experience

[illegible] [illegible]

[illegible] clarifying the road and the material does [illegible].

MR. [illegible]: Thank you very much.

[illegible] the [illegible] relevance of [illegible].

MR. [illegible]: May I call on Professor [illegible] to talk about our [illegible] in terms of research and evaluation.

PROF. [illegible]: Mr. Chairman, Lady and gentlemen, I will be [illegible] on the matter of research and evaluation. [illegible] I think both are included in the term "research". Certainly it can be argued there is a great deal of research accumulated in the United States and elsewhere. It can also be argued, however, this data could be used in our country, but I believe that the kind of research and evaluation we need must be more [illegible] and relevant to our problem under the conditions we have in Canada.

In that case we have very little accumulated. There is a great need to test the kind of basic education [illegible] can [illegible]. Should we do what knowledge they have and what application to health or [illegible]. This know-how is a matter especially in the area of research and evaluation. We should be [illegible] the [illegible] of research and application in Canada for [illegible] in health.

MR. [illegible]: Thank you very much.

MR. [illegible]: Mr. Chairman will explore the [illegible] of health services in Saskatchewan.

MR. [illegible]: Yes, will be very [illegible] [illegible] and [illegible] systems, the experience

we have had in visiting schools has shown there is an inequality of health services. I think we can compliment many of the health units and the chore which they have done with the elementary schoolchildren.

we have had in visiting schools has shown there is an inequality of health services. I think we can sometimes many of the health units and the score which they have done with the elementary schoolchildren.

But in the last four or five years we have seen an explosion in the population of the secondary school, and because of the need for students staying in school much longer, because of the need for technical training, and the simple reason that unemployment is creeping in, we have a tremendous increase in our secondary school population. Now, from my observation and surveys, visiting schools, the health services as provided by health units, is not adequate for the secondary schools because of the increased numbers. We are going to run into a percentage of students who need attention, and at the same time schools are becoming much larger. It is easier to give them some service, and at the present time some areas are attempting to provide medical services through the doors of education. This I think is a duplication, and drives a wedge between the health services provided by the health departments and education.

On the other hand, I feel that these services can be expanded, and at the same time there is another need here, and that is, as we suggested a few years ago, a school health committee, where the health services people and the education people in a community, the key people could at least meet once a year, and provide some kind of continuity, and look at the needs of that particular school age group.

I think we function too much in compartments in education and health, and these health services should be integrated much more closely than they have been, and I feel that a study in a number of

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I think we function too much in compartments in education and health, and these health services should be integrated much more closely than they have been, and I feel that a study in a number of

pilot centres would begin to show how the health authorities and the school authorities could work much more closely together for the benefit of the students, and again there is another inequality between the urban and the rural.

The elementary schools, particularly in the urban centres, are quite adequately provided for, but once you get out into the rural elements, the services are not nearly as well looked after, and I think this would be an opportunity, through a study like this, for the nurses, the doctors, the teachers and so on, the janitors, the teachers in various subjects, and the students themselves, because I find that in some schools where there has been a student health group they come up with more of the answers than some of the teachers, and I think that in any committee like this, or study, we should look after the interests and needs of these children, and involve them, rather than just telling them what goes on.

THE CHAIRMAN: In connection with this particular recommendation, but it is relevant to a number of others, you will appreciate that these are matters dealing primarily with education. I know they have a health connotation.

MR. WRIGHT: Not the health services, sir, given by health units.

THE CHAIRMAN: No, but I mean the matter of, insofar as the schools are concerned and so forth, and even the health units, these are matters within provincial jurisdiction.

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MR. [illegible]: Not the health services, [illegible].

THE CHAIRMAN: Yes, but I mean the matter of, insofar as the schools are concerned and [illegible], and even the health unit, these are matters within provincial jurisdiction.

MR. WRIGHT: Yes, provincial jurisdiction sir.

THE CHAIRMAN: And while we are concerned, I mean to say in a general way, with this picture of physical health, it couldn't be ignored, when it comes to particular functions or programs within the provincial sphere, you can quite appreciate that it is quite beyond the scope of this Commission to start to tell provinces what to do. Provinces are, as you know, quite touchy on this point.

MR. WRIGHT: The idea of a pilot though is a study, even conducted by the province, could reveal this to themselves, if some support were given.

THE CHAIRMAN: Oh yes, I am not saying that your basic approach here this afternoon is not perfectly relevant and proper. It is only in terms of individual projects which fall exclusively within the provincial jurisdiction that I make reference to.

MR. WRIGHT: You wouldn't like to put any tags on the federal money that comes through provincial sources.

THE CHAIRMAN: I don't think we will be asked to.

MR. SPEIRS: Isn't it true sir that your terms are very broad deliberately, and one province I believe said that your existence is almost an impertinence in view of the fact that health is a provincial prerogative, but it is an impertinence they put up with, because the federal government has money to distribute.

[illegible] education air.

THE CHAIRMAN: And what we are concerned, I mean to say in a general way, with this picture of material health, it couldn't be ignored, when it comes to particular functions or programs within the provinces, as we, you can quite appreciate that it is quite beyond the scope of this Commission to start to tell provinces what to do. Provinces are, as you know, active bodies in this nation.

Mr. WRIGHT: The idea of a pilot through is a sound, even conducted by the provinces, could reveal this to themselves, if some support were given.

THE CHAIRMAN: Oh yes, I am not saying that you are in disagreement here this afternoon is not particularly strong and proper. It is only in terms of individual projects which exclusively within the constitutional jurisdiction that I am referring to.

Mr. WRIGHT: We wouldn't like to put any taxes on the federal scene. That comes through [illegible].

THE CHAIRMAN: I don't think we will [illegible].

Mr. [illegible]: Isn't it true sir that your terms are very broad indeed, and one presumes I do have said that your existence is almost an imperatives in view of the fact that health is a provincial prerogative, but it is an inescapable they not up with, because the federal government has money to distribute.

THE CHAIRMAN: Well, nobody has been quite that impertinent. The constitutional position has been spelled out by one or two provinces, not only one or two, but by several provinces.

MR. BLACKSTOCK: I think our intention in putting this recommendation was that the Commission might urge the unification of practice across the country, rather than the implementation of any specific studies.

THE CHAIRMAN: Yes, general recommendations are one thing. It is when you start to spell them out into particular programs, or directives, that would involve us in difficulty.

COMMISSIONER FIRESTONE: On this point, if you are thinking in terms of the federal government encouraging the provinces to develop a program of health services in schools of minimum standards, if this was what you had in mind in one way or the other, then we would need a little bit of guidance from you of what you would consider to be desirable standards, minimum or otherwise.

MR. SPEIRS: One thing that Mr. Wright mentioned in our pre-conversation was the establishment of county health units, which has probably been urged upon you by other units has the effect of draining the nurses out of the schools into the community, so that services previously provided are now being withdrawn.

COMMISSIONER FIRESTONE: Is there anything additional you would like to add perhaps?

THE CHAIRMAN: We had a variation of

quite that interesting. The constitutional position has been spelled out by one or two provinces, not only one or two, but by several provinces.

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COMMISSIONER WRIGHT: Is there anything additional you would like to add perhaps?

DR. CAMPBELL: We had a variation of

that in British Columbia, of that idea, of that complaint.

COMMISSIONER FIRESTONE: What I was specifically trying to find out, if you have any views as to what would be desirable standards, both for urban as well as rural areas, to be provided in terms of health services in schools?

MR. WRIGHT: At the secondary school level it is so inadequate at the present time we would have to have some study, to see how many they can serve, whether one nurse to 5,000. In the States you can get indications of this, but there is nothing that I know of to base a suggestion on in Canada. Maybe I am not aware of the whole situation.

COMMISSIONER FIRESTONE: Did I understand that there are schools where you consider the present practice to be reasonably satisfactory?

MR. WRIGHT: Yes, in some of the urban centres.

COMMISSIONER FIRESTONE: What kind of standards do these schools employ, and maybe we can learn from the experience where you consider this experience to be adequate?

MR. WRIGHT: In some of your larger schools, where you have a nurse, if they run about 1,400 students you need a nurse full-time. Once you get down to schools of less size, a nurse may be just in there half a day a week, and share with another school, but again that will vary with the income bracket, and the type of community in which the school is located, and the

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MR. WHICHER: At the secondary school level it is so important at the present time we would have to have some study, to see how many that can serve, whether one nurse to 5,000. In the states you can get indications of this, but there is nothing that I know of to base a suggestion on in Canada. Maybe I am not aware of the whole situation.

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MR. [illegible]: What kind of standards do these schools employ, and maybe we can learn from the experience they can consider this experience to be [illegible].

MR. [illegible]: In some of the larger schools, where you have a [illegible], in they run about 1,500 students you need a nurse full-time. Then you get down to schools of [illegible] size, a nurse may be just in there half a day a week, or [illegible] secondary school, but again that will vary with the income [illegible], and the type of community [illegible] is located, and the

income bracket you are dealing with, but I think in the main a minimum standard could be established. I am not fully conversant with the whole picture at the present time, but I know there is a need there. It should be perhaps one in 14, 15, 1600. Perhaps the nurse on the panel could give us some indication?

COMMISSIONER BALTZAN: What does the nurse actually do in that one day, or half day, in relation to the problem you are presenting to us?

MR. WRIGHT: In this case the teacher serves as a screening agent, and with 1,400 secondary school students, in a fair percentage of them there will be some indication of illness, such as a rash, and teachers can refer them to the nurse.

THE CHAIRMAN: There is a very well developed program in Saskatoon, Dr. Baltzan.

COMMISSIONER BALTZAN: I am well aware of that, Mr. Chairman. But this is related to the illness portion now?

MR. WRIGHT: Yes.

COMMISSIONER BALTZAN: But more in relation to that in which you are primarily interested, and that is the positive approach towards keeping the well well or weller, what do you think?

MR. WRIGHT: I think there is a point where you are handling a class of 40 or 50 boys, there is enough indication. This lad is slower today, or pale. This is the lad you can refer to the nurse. The teacher does not take the prerogative of diagnosis but ---

COMMISSIONER BALTZAN: But sir, I am

income important you are dealing with, but I think in the main a minimum standard could be established. I am not fully conversant with the whole situation at the present time, but I know there is a need there. It should be perhaps one in 14 or 15, 1500. Perhaps the nurses on the panel could give some indication?

[illegible] MATRON: What does the nurse actually do in that one day, or her 4 day, in relation to the doctor you are presenting to us?

[illegible]: In this case the teacher serves as a screening agent, and with 1,400 secondary school students, in a fair percentage of them there will be some indication of illness, even as a cold, the teachers can refer them to the nurse.

[illegible]: There is a very well developed process, in fact, Dr. Mattson.

[illegible] MATRON: I am well aware of that, Dr. [illegible]. But this is related to the illness section [illegible]?

Dr. WATTS: Yes.

[illegible]

relation to that in which you are primarily interested, and that is the positive approach towards keeping the well well or [illegible], what do you think?

Dr. [illegible]: I think there is a point where you are [illegible] a class of 40 or 50 boys, there is sudden indication. This lad is slower to[illegible], or pale. This is the [illegible] you refer to the nurse. The teacher [illegible] the [illegible] of disease but [illegible]. And so, I do

very much interested and most sympathetic I want to assure you, but you are still crossing the border towards ill health, and surely the nurses and the public school doctor and that sort of thing, at least attempt to look after them? I am still thinking in terms of what they should do in the way of training. How does she inform children about the kind of things that you and I and all of us are interested in, to stay well?

PROF. LIFE: I think that the type we are talking about when we talk about positive health is an ideal. I know what you mean, and I think that the nurse, if she didn't have so many ill children to treat, if more of these children were healthier, then she could spend more of her time working with the health educator in the school, and working with the administration of the school, to help to make the environment in that school a healthier place.

Am I talking on the right line now?

COMMISSIONER BALTZAN: Oh yes, we are getting closer together. One a healthy nurse and one a sick nurse.

PROF. LIFE: But I think this is important though, but right now where we do have nurses in the schools, either if the nurses there are full-time, she is so preoccupied with little problems. The children are really not sick, but you know, there are little problems that she does not have time to work with the health educator, but I think this is the ideal.

MR. SPIERS: If we could on with the

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WOOF, LEFT: I think that the type we are talking about when we talk about positive health is an ideal. I know that you mean, and I think that the nurse, if she did have so many ill children to treat, if more of these children were healthier, then she could spend more of her time working with the health education in the school, and working with the administration of the school, to help to make the environment in that school a healthier place.

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CHAIRMAN: BUTTRAM: Oh yes, we are getting closer together. The a healthy nurse and the a sick nurse.

[illegible]

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MR. [illegible]: [illegible] on the

next two resolutions it might help to put some flesh on the bones of this skeleton. I was quite disturbed about the trend we were taking, but apparently now we should be specific.

Number 6, it is recommended that the Commission urge the initiation of studies to help standardize procedures for the medical examination of school children, e.g. by developing a standardized medical examination form by which much duplication of effort could be eliminated when pupils transfer from one school to another. The same form would meet the requirements of summer camps, Y.M.C.A.'s, boys' clubs, et cetera. Standard classification procedures whereby the examining physician indicates which activities in the physical education program are desirable, and which must be restricted, would also help to clarify a situation which is confusing to physicians, parents and children alike.

Does that, sir, help to suggest what might be done by the health services to give this a positive emphasis?

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Does that, sir, help to suggest what might be done by the health services to give this a positive approach?

dpw

COMMISSIONER BALTZAN: I think it does to a great extent.

MR. SPEIRS: Then try No. 7 on for size:

"It is recommended that the effectiveness of the present system of disseminating health information (pamphlets, periodicals, booklets, etc.) by all agencies, both private and public be studied."

Now, let me say here that no criticism of the quality of the present pamphlets is contemplated here; it is their non-availability.

"As regards pamphlets ... where a city person can't get pamphlets which are available to a rural person."

THE CHAIRMAN: I am afraid this Commission won't ---

MR. SPEIRS: Won't study it?

THE CHAIRMAN: It isn't a matter of not studying it, it is not part of the paraphernalia which comes within the scope of the inquiry. Surely these are matters which are curable at the local level you are complaining of?

MR. SPEIRS: We have tried it, sir, and we have tried it at other levels, too. It is the material that comes from the federal level to a certain extent.

COMMISSIONER FIRESTONE: Are you

COMMISSIONER BAILTZAN: I think it

MR. SLOCUM: Then try No. 7 on for

"It is recommended that the effective-
ness of the present system of disseminating health information (pamphlets, periodicals, booklets, etc.) by all agencies, both private and public be studied."

Now, let me say here that no criticism of the quality of the present pamphlets is contemplated

"is regards pamphlets ... where a

which are available to a rural

person."

MR. CHATTERTON: I am afraid this

Commission won't ---

MR. CHAIRMAN: It isn't a matter of not studying it, it is not part of the paraphernalia which comes within the scope of the inquiry. Surely these are matters which are curable at the local level you are concerned ---

MR. CHRIST: We have tried it, sir, and we have tried it at other levels, too. It is the material that comes from the federal level to a certain extent.

COMMISSIONER PETERS: Are you

suggesting that if a person writes to Ottawa for a pamphlet they are refused the pamphlet?

MR. SPEIRS: No, they are delayed. It goes back to the local level and to the nurses' level. By the time you get down to the nurses' level the choice is pretty slim pickings.

COMMISSIONER FIRESTONE: Do you know of any specific case where somebody has written to the Federal Department of National Health and Welfare asking for a pamphlet and they were refused it?

MR. SPEIRS: This goes on all the time with teachers.

COMMISSIONER FIRESTONE: You have no specific document in that regard?

MR. SPEIRS: No.

COMMISSIONER BALTZAN: Your organization that you are representing here today; are you representing the physical education teachers?

MR. SPEIRS: No, only in part. The recreation people may also belong but they are people who are professionally engaged in health education and recreation.

COMMISSIONER BALTZAN: It is an Ontario branch?

MR. SPEIRS: No. We are representing the Canadian Association.

COMMISSIONER BALTZAN: I can see my confusion, because I see on the heading of this thing something about the Toronto Board of Education.

MR. SPEIRS: I thought I had explained

suggestions that if a person wanted to obtain for a specimen that they were refused the opportunity?

It goes back to the local level and to the professional. By the time you get down to the professional level the choice is pretty slim, of course.

PETERS: Do you know of any specific case where someone has written to the Department of National Health and Welfare asking for a pamphlet and they were refused it?

MR. SHAW: I have done on all the time when on television.

CHAIRMAN PRESENT: You have no specific document in that memory?

MR. PETERS: No.

CHAIRMAN PRESENT: Your organization that you are representing here today, are you representing the medical association teachers?

MR. DE LEN: We, only in part. The recreation people may also belong but they are people who are professionally engaged in health education and [illegible]

MR. [illegible]: It is an [illegible]

MR. PETERS: No. We are trying getting the [illegible]

CHAIRMAN PRESENT: I can see in conclusion, because [illegible] on the heading of this thing concerning about the [illegible] of education.

MR. [illegible]: I thought I had explained

that at the first. That is probably due to my letterhead or something of that sort.

THE CHAIRMAN: Have you something to add, Mr. Blackstock?

MR. BLACKSTOCK: Except this, and I think our concern about publications and why we bring it to the attention of this Commission, is that there is a great deal of variation in many agencies of distributing these who let it be known to the public that they are available through them, and this makes for awkwardness.

Secondly, and perhaps more important, the content of many of these has not been correlated, so that one pamphlet on a given topic given out by one agency carries different information than another on the same topic, and when it comes to health that is a serious problem, and our problem at the teaching level is to give accurate information that is generally accepted by all the related professional organizations or disciplines in our society, because at the moment we have not worked out a way of co-ordinating our learning and then our writing and then consequently our teaching. We have textbooks that are inaccurate because they are outdated, that haven't been vetted by someone who has suitable knowledge.

What we are suggesting is that the Commission could urge that health information and education be centralized or at least vetted by all the necessary disciplines that have something to contribute to it.

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the agencies. Usually [illegible] they are concerned to central-
ize to it.

COMMISSIONER BALTZAN: What textbooks have you got on health education or physical education?

MR. BLACKSTOCK: Very few written by Canadians. Mr. Speirs is a co-author with Dr. Phair. There are about half-a-dozen of them on health education and about four or five written by Canadians. In most cases, we use foreign textbooks, British, U.S. and some European.

COMMISSIONER BALTZAN: It sets out norms for age, sex and build?

MR. BLACKSTOCK: Yes.

COMMISSIONER BALTZAN: On a healthy state?

PROF. LIFE: For American children but not for Canadian children necessarily.

MR. BLACKSTOCK: Or British children.

COMMISSIONER BALTZAN: I certainly commend you on your main theme, and that is this philosophy or approach that is positive health rather than the other type which is often preventive, negative approach.

I see you have some reference here about the lavish provisions for physical and health education at all levels in one other country, on page 2 of your preamble, and my question is: because of that lavish provision about which you seem to have knowledge, what evidence have you of the results of that lavish provision?

In other words, are the people in this country growing up so much healthier, staying so much

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healthier; are they so much better off? Not that I am not in agreement with the idea.

How far have they gotten as a result of all this?

MR. BLACKSTOCK: How far have our programs, sir?

COMMISSIONER BALTZAN: No, the only place where they have this lavish thing.

PROF. LIFE: We don't have very much information on that. The information we have is very lavish, they make great claims, but we don't have much information on it.

COMMISSIONER BALTZAN: Gentlemen, I have seen and I give you very great credit for the most lavish underground subways we have in the world, and that is lavish, it is beautiful and it is grand, and I have also seen, not so long ago, the living quarters, etc., etc. So that in comparison, the statement of a lavish provision, the end results of that are two different things, and that is why I put that question: have you any positive information about the value of this lavishness?

PROF. LIFE: We believe that leadership is very much more important than lavish facilities. We would like to see adequate facilities for physical education and health recreation completely throughout our country, but we are much more interested in leadership.

MR. SPEIRS: I think we can help to document that for you, because we have been working the

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MR. BRINKLOOK: How far have we [illegible]

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MR. BRINKS: I think we can help to convert that for you, because we have been working in the

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COMMISSIONER BALTZAN: Let's just say that you are going to disseminate it in the journal to more Canadians. That would make us happy.

MR. SPEIRS: That would make us insular. I think that completes our presentation, sir, unless there are questions.

THE CHAIRMAN: Thank you very much for your attendance and for your, perhaps, little more unorthodox form of presentation, in a sense. I think we can assure you, as far as the subject of health through proper physical education and recreation is concerned, that that is a subject of great interest to us and we are very happy to have the whole subject accented in the way you have done it this afternoon, and we want to thank you for it.

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S U B M I S S I O N OF

THE UNITED ELECTRICAL, RADIO AND MACHINE WORKERS OF AMERICA

---EXHIBIT NO. 308: Submission of the United Electrial, Radio and Machine Workers of America.

APPEARANCES:

MR. C.S. JACKSON
MISS E. ARMSTRONG
MR. CARL DURST
MR. ROBERT WARD

MR. JACKSON: I would like to introduce the delegation I have with me: The two representatives of our National Executive are Miss Evelyn Armstrong, who is President of the General Electric Local and Mr. Carl Durst who is President of a Toronto local embracing about twelve plants and a representative of our Publicity Department, Mr. Robert Ward.

If I may in introducing our contributions and recommendations to the Board we as representatives of the working people look at the question of health as being primarily the responsibility of Government. There is a direct correlation between the health of the working people, their families and the health of the nation's

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economy. We are constantly encouraged and asked to pay attention to productivity because of its necessity to the nation's well-being. We strongly urge that the Commission recognize without a healthy working group there could not be any improvement in productivity.

In drafting our recommendations to the Commission we have been conditioned, if you like, by our experience over a number of years of representing the working people. The United Electrical, Radio and Machine Workers of America and our particular union has represented the electrical industry for the past 26 years in Canada. From time to time in the course of our deliberations and conventions we have resolved on many questions that impinge on the basic question of health. We do in the brief point to the conditions confronting the industrial worker in his working environment. There are standards of basic health of the people of the nation and our concern is not only about coordination, but preventive aspects of disease and the basic responsibility of Government to do everything in its power to provide all the conditions, the environment, educational etcetera, to guarantee the good health of the people. We have summarized our recommendations on Page 3 of our brief. I would like just quickly to run over those and possibly expand briefly on one or two.

1. A comprehensive health program for the Canadian people is a national responsibility, which the federal government must acknowledge.

2. In this program, public health promotion and preventive medicine must now be given much more prominence.

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1. A comprehensive health program for the Canadian people is a national responsibility, which the federal government must accept.

2. In this program, public health promotion and preventive medicine must now be given much more prominence.

3. Environmental contamination must be effectively controlled and offenders forced to pay the costs of nuisance elimination.

4. Factory Health and Safety Acts should be passed in all provinces to remove, control and protect against occupational health hazards.

If I might add a point in that connection, two previous Royal Commissions, the Commission headed by Mr. Justice Roach several years ago in dealing with The Compensation Act in Ontario and the more recent Industrial Safety Commission headed by Judge McAndrew both have dealt extensively with health aspects of legislation and the need for extensive revision of existing legislation in terms of protecting health. I would assume your Commission has before it these various reports and we would draw your attention to them.

THE CHAIRMAN: We will have access to them.

MR. JACKSON: We would draw your attention to them as containing some rather important recommendations dealing with industrial health.

5. Government encouragement should be given to medical colleges to train specialists on industrial health problems and full government assistance should be given to students willing to take degrees in this field and work in it after graduation.

We consider this fifth point one of the most important points we are making before your Commission. Our study of what has taken place in the field of industrial health and the examination and discovery

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of industrial disorders leads us to the conclusion in Canada, in fact in North America as yet very little has been done to study the effects of the changes in technology in industry today. By and large there has been an elimination or substantial reduction in physical effort required by the average workman through new technological developments through the beginnings of automation in this country, small as yet, but looming larger somewhere in the future. Some interesting studies we came across were made in the Fiat plan in Turin in Italy on this question on the effect on humans coming from a heavy labouring job taking over a job of considerable responsibility but very little physical effort. We were very interested in the conclusions drawn by the investigators in that particular situation, of the development of what they called fatigue neurosis. To our knowledge only in one other country is there any of this type of investigation taking place at the moment and that is in West Germany. Dr. Sager in Canada has been examining the question of stress, but there is a difference in our opinion, although we are not medical people, between the effects of stress and fatigue neurosis that deals with the tension a person is under constantly to be able to meet the precise moment, a precise action at a precise moment even if he is doing nothing in between for fifteen and twenty minutes. We feel many of the ailments that are present today among working people have their source in either stress or fatigue neurosis. Insufficient medical research has been done in the field to allow the proper diagnosis of the ailments, and to seek out their

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proper source. It is for that reason we feel that the Government should sponsor, subsidize where necessary special courses in industrial hygiene, industrial health and industrial disease and even to the point in our opinion where a special degree of industrial medicine could be, in our opinion, worthwhile as an encouragement for people to undertake this study. It would then require, of course, support and subsidization to maintain them in the field because it would be a Government service rather than a private enterprise occupation for such degree holders. We think it is vital.

THE CHAIRMAN: You don't see them employed by industry?

MR. JACKSON: Not to a sufficient degree in our opinion to be completely effective. We have had some experience with what we consider from time to time lack of objectivity on the part of medical personnel who owe their income solely to the corporation. We would see it as a Governmental responsibility to encourage, to provide the income for such people.

6. Medical research expenditures by governments should be increased to at least the equivalent of $3.per person a year.

7. Drug prices should be drastically lowered and profiteering on the peoples' illness stopped by nationalizing drug manufacturing and operating needed enterprises as Crown Companies.

8. The economic impact of sickness on large numbers of Canadian families can only be properly absorbed by a comprehensive, free medical service coupled with income maintenance while off work.

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7. Drug prices should be drastically lowered and profiteering on the peoples' illness stopped by nationalizing drug manufacturing and operating needed enterprises as crown companies.

8. The economic impact of sickness on large numbers of Canadian families can only be properly supported by a comprehensive, free medical service coupled with income maintenance while off work.

9. The most equitable method of financing the nation's health bill is from general revenues based on the greatest possible degree of "ability-to-pay" taxation.

10. Income maintenance while not earning because of illness should be handled in the same manner as unemployment benefits, but financed entirely out of general revenues.

11. The additional government expenses for a full health program with income maintenance, estimated at $1,409 millions, can be met by diverting this amount from the $1,702 million military budget, still leaving enough for a reasonable defense program.

That summarizes the points we have made and which we have documented in our presentation before you. Our conclusions on Page 27 deal with our estimate of costs of a full public health program for Canada. It is summarized in this way:

Present government expenditures for health:

	est. millions in 1961	
By Federal (1)	$366.	
By Provincial(2)	500.	
By Municipal (3)	100.	$966.
Additions to complete public health system: would be -		
Family health expenditures of		1,050.
Family income maintenance during illness		359.
TOTAL COST		2,375.

(1) 1961/62 estimates of Dept. of National Health & Welfare excl. family allowances and old age assistance

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Present government expenditures for health:

	$ millions in 1951
By Federal (1)	308.
By provinces (1)	309.
By Municipalities (1)	100. 708.
Additional to cover the public health expenses:	
would be -	
Family health expenditures of	1,079.
Family income maintenance during illness	829.
TOTAL COST	2,616.

(1) Based on estimates of Dept. of National Health & Welfare excl. family allowances and old age assistance

(2) rough estimate from fiscal 1961 provincial expenditures for health and social welfare

(3) rough estimate from 1958 municipal expenditures for health.

Since $966 millions of this total are already included in various governments' expenditure budgets, it leaves the total additional cost to be covered by government as $1,409 millions.

How is the additional $1,409 million government burden to be covered? We suggest the necessary funds are already being raised by taxation, but spent on unproductive military affairs. The military budget for fiscal 1962-63 is $1,702 millions. What better example could Canada set the world today than by diverting a substantial part of the military budget to pay for a complete public health program for the Canadian people?

In all seriousness, we ask --- of what use is it to recommend measures to improve the health care of the Canadian people when the clouds of complete nuclear disaster continue to gather ever more ominously over our heads? In concluding this brief, which looks towards a healthier, brighter future for Canadian people, therefore, we earnestly call on the federal government to declare itself unalterably opposed to the development, tests and use of nuclear weapons and for total disarmament and peace. This would meet a crucial social need and also do much to create the kind of international climate in which negotiations to reach compromise solutions can succeed, and so reduce the danger of nuclear war.

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of the points which we make in our brief and which we feel have been documented throughout.

THE CHAIRMAN: Mr. Jackson, you summarize your recommendations. You begin with number 1 at the top of Page 3: "A comprehensive health program for the Canadian people is a national responsibility which the federal government must acknowledge". Being practical can you see the provinces of Canada giving up what is their constitutional position in regard to health so that the Federal Government can do what you say it should do here?

MR. JACKSON: Well, I think there is quite a division of opinion in this country as to the extent to which the B.N.A. Act prevents or permits the Federal Government taking over broader responsibilities in many fields. I think there is an obligation on the part of the Federal Government in the first place for the health of the people and that being the case then the means of securing their right to do so is in their hands.

THE CHAIRMAN: This recommendation is made with full knowledge of the Constitution.

MR. JACKSON: Of the Constitutional arguments, I would say. I am not a Constitutional lawyer, but I think there are two sides to it.

THE CHAIRMAN: I am not suggesting it that way, but it is a matter of Provincial claims, something that is pretty widely known.

MR. JACKSON: Right.

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THE CHAIRMAN: Now, in (8) you say that the economic impact of a sickness, et cetera, can only be properly absorbed by a comprehensive, free, medical service. What do you mean by the word "free" there?

MR. JACKSON: We mean paid out of general revenue by the company, without any premium paid by the individual citizen. There are varying degrees of that existing in the world today, I think, in different countries.

COMMISSIONER FIRESTONE: Mr. Jackson, if I understand the essence of your proposal correctly, you are, you and your associates are in favour of a comprehensive, national health care plan for Canada, on a compulsory basis, State-operated, is that correct?

MR. JACKSON: That is correct.

COMMISSIONER FIRESTONE: You appreciate, sir, that we have had a number of groups raising objections to such a proposal, and one of the objections that have been raised has been that the introduction of such a proposal would involve the control of how doctors practise medicine and doctors object to it.

MR. JACKSON: Right.

COMMISSIONER FIRESTONE: What would be your answer to that?

MR. JACKSON: We cannot find too much sympathy with the position of the C.M.A., or the medical profession, because I don't think that the experience in countries where there is a substantial measure of medical control of the medical profession

Mr. [illegible]: Sir, in (8) you say that the economic impact of a sickness, at cetera, can only be properly absorbed by a comprehensive, free, medical service. What do you mean by the word "free"?

MR. [illegible]: We mean paid out of general revenue by the company, without any premium paid by the individual citizen. There are varying degrees of that situation in the world today, I think, in different countries.

If I understand the essence of your proposal correctly, you are, you and your associates are in favour of a comprehensive, national health care plan for Canada, on a compulsory basis, tax-operated, is that correct?

Mr. [illegible]: That is correct.

Sir, that we have had a number of groups raising objections to such a proposal, and one of the objections that have been raised has been that the introduction of such a proposal would involve the control of how doctors practise medicine and determine upon it.

Mr. [illegible]: Right.

[illegible]: What would be your answer to that?

Mr. [illegible]: We cannot find too much anxiety with the position of the C.M.A., on the medical profession, because I don't think that the experience in countries where there is a substantial measure of medical control of the medical profession

through comprehensive medical plans, I don't think the experience bears out at all the concern which is being expressed in the case of Saskatchewan by the Medical Association, and which I think was expressed to your Commission by the Canadian Medical Association quite recently.

We don't share their belief in it down-grading the relationship of the doctor to the patient in the first place. On the contrary. We would think that that relationship would be on a much higher level when the cash incentive was removed from the situation, so that in our opinion we view the opposition of the Medical Association well, we look at it askance. We have known of it, we have had many of our resolutions over the years, both here and in the United States, and quite frankly we find no real substance in their argument.

COMMISSIONER FIRESTONE: Well, one point of view that one could put forward is, is that not discrimination against one particular profession? Why put this control of how doctors should practise medicine, if similar controls are not imposed on lawyers, accountants, or in your case perhaps members of the United Electrical, Radio and Machine Workers of America?

MR. JACKSON: From where we sit we are under very heavy control legislatively, and in some other ways, as union people and as workers in the industry, and we are not frightened of controls if the controls are operated in the interest of the national good. Now, we feel that health being what it is in terms of the needs of

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the individual, a primary need of the individual for good health, that a government-controlled medical plan is the only way in which there is going to be lack of discrimination in the application and the practise of medicine to the mass of the people.

In that sense we don't view the control aspect in the sense in which it is being raised as a horrendous situation. On the contrary, we feel that that is the direction in which our society is moving generally.

COMMISSIONER FIRESTONE: Another criticism of that proposal which you have put before us is that a State-operated plan would contribute to reducing the quality of medical care services provided to the Canadian people, and that that would not be in the national interest. What would be your reply to that observation?

MR. JACKSON: I don't see how it could or would reduce the inequality. First of all, we don't agree that quality exists today. We think there is discrimination, based on income.

THE CHAIRMAN: I think the word was quality, and not inequality.

MR. JACKSON: How are you using the term inequality in the first place?

COMMISSIONER FIRESTONE: The word is quality of medical care.

MR. JACKSON: In what way is quality related to a particular method of payment for services? We don't see that the method of payment for services has

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Mr. DAVIDSON: The way in quality related to a [illegible] method of payment for services? We don't see that the method of payment for services has

anything to do with the quality that is rendered by the practitioner.

COMMISSIONER FIRESTONE: Well, one of the reasons that was given to us, and I am passing it on to you as I understood it, was that if government interferes in how the medical practitioner is practising medicine, it would affect the freedom in which he can practise medicine. He may be told for example that the financial resources of the government insured plan do not permit to cover certain medical services which he in his own judgment would feel are required in the interests of high quality medical care. The argument of budgetary consideration was put forward to us. I don't want to exhaust the whole list. I am just raising the question of principle which was put before us as an objection.

MR. JACKSON: Frankly, we view a lot of those so-called principles as straw men, because the mere fact it would centralize our control, if you want to use that term, direction I would rather prefer, of the application of medicine, or rather of meeting the needs of the people, I don't see that that in any way confirms the opposition of the medical association.

COMMISSIONER FIRESTONE: May I perhaps be a little more specific, to be helpful to you. One point that has been put forward to us is that government, and any government plan would have to be based on a budget, and assuming that the budget that governments had provided for medical care services in a given year turns out to be inadequate, what are doctors to do?

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Are they to cut down the medical care services that they provide patients, or are they to provide such additional services out of the goodness of their heart, and thus subsidize it, or do it for reasons of charity?

MR. JACKSON: How does that differ from any other aspect of government administration? They operate within a budget and give the service the budget permits, and possibly some voluntary service in addition by individuals. Why would they have to cut this down in a government administrated plan?

COMMISSIONER FIRESTONE: Well, they feel, as I understand it, and again I am subject to correction, I don't want to speak for the medical profession, that you are removing the incentive for them to practise the medical profession as they see fit under our present system.

MR. JACKSON: Well, this question of incentive. There are various forms of incentive of course, and the doctors are speaking solely of cash incentives, and the whole question of the value of a particular incentive has to be examined in its particular context. Our experience in industrial relations with some corporations we find that cash incentive is something that the companies no longer find as productive, and that they are negotiating with us to eliminate the cash incentive in terms of a bonus for additional production, et cetera.

I think that that would not be, and should not be under a government administrated plan the only incentive, the cash incentive.

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COMMISSIONER FIRESTONE: Under a government administered plan as you envisage, and using the phrase compulsory, do you refer to compulsion for the recipients of medical care services, and those providing the service? In other words, do doctors have to operate under the plan or would you envisage that they could operate if they so wished, outside the plan?

MR. JACKSON: I would think that the ultimate would be that they would operate completely within the plan.

COMMISSIONER FIRESTONE: What happens if a doctor does not wish to operate under the plan?

MR. JACKSON: Well, what happens if the people do not obey the laws in the legislation of the country in other fields? You cannot draw one particular set of rules for the doctors that does not prevail for other types of legislation.

COMMISSIONER FIRESTONE: These are the sort of projections that we have run into, and I wonder what your views are?

MR. JACKSON: As terms of our recommendation, we proposed nationalization of the drug industry, and are in favour of nationalization in various sectors of the economy as being the only efficient way contrary to our private enterprise way, if you will, that there are certain fields that are of such vital importance to the people as a whole that unless they are administered centrally, that there is bound to be discrimination in those fields.

COMMISSIONER FIRESTONE: What would be the answer to doctors that would say that if you

government administration plan as you envisage, and using the phrase compulsory, do you refer to compulsion for the recipients of medical care services, and those providing the services? In other words, do doctors have to operate under the plan or would you envisage that they could opt in if they so wished, outside the plan?

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[illegible]

[illegible] the answer to doctors that would say that if you

forced them to belong to a plan that they don't wish to belong to, that they may want to leave and say move to the United States? Would it be in Canada's interest to lose a large number of well qualified men that cost Canada many thousands of dollars to educate?

MR. DURST: I would like to say that if a doctor were so mercenary that he only thought of the money involved, and wished to leave the country for those reasons rather than his intended profession, to make people better, that the country would be better off without him.

COMMISSIONER FIRESTONE: But the doctor may say that he is moving because he believes in the principle of freedom of choice, the principle of freedom of deciding what his future will hold.

MR. JACKSON: That is his right, but I don't think history bears it out in movements of any substance where medical plans have been introduced.

COMMISSIONER FIRESTONE: In other words, if I understand you correctly, you would not be too concerned about Canada losing too many medical people as the result of the introduction of such a comprehensive, State-operated health plan as you recommend?

MR. JACKSON: I would put the positive, that under a State-operated plan there would be greater encouragement and incentive for the younger people to come forward, and that the replacements would more than outweigh the losses.

COMMISSIONER FIRESTONE: What is the basis for that belief sir?

[illegible]

[illegible]

[illegible]

MR. JACKSON: Well, I cannot spell out to you the Hippocratic Oath, but if we are operating within the framework of that principle, I would say that the incentive for a medical man is the service that he can give to his people in maintaining health, and that that would give him greater honour in the community than the fact that he can amass a small fortune in a short period of time on a discriminatory basis, based on the income of the patients.

COMMISSIONER FIRESTONE: The other point that has been made that may affect the quality of medical care services, is that the introduction of a comprehensive medical care plan might make it difficult to provide all the medical care services that would be covered, and therefore, since the doctor has only got so many hours in a day, and so many days in a week that he can practise medicine, the medical care services provided would be reduced, at least for a period, until the supply of doctors has caught up with the demand for their services, and that may take a number of years to achieve that improved balance of supply and demand, and this is a point that has been put forward to us, not only with respect to the medical profession, but perhaps even in stronger terms for the dental profession.

What is the answer to this sort of observation?

Mr. JACKSON: Well, I cannot argue out to you the economic law, but if we are operating within the framework of that principle, I would say that the incentive for a medical man is the service that he can give to his people in maintaining health, and that that would give him greater honour in the community than the fact that he can do as a small fraudsman in a short period of time on a discriminatory basis, based on the income of the patients.

Dr. [illegible] MILLS: The other point that has been made that any attempt at quality of medical care services is that the introduction of a contributory scheme, or some other means to attempt to provide all the medical care services that would be covered, and therefore, since the doctor has only got so many hours in a day, and so many days in a week that he can practise medicine, the medical care services provided would be reduced, at least to a period until the supply of doctors has caught up with the demand for their services, and that takes a number of years to achieve that improved balance of supply and demand, and this is a point that has been put forward to us, not only with respect to the medical profession, but perhaps even in stronger terms for the dental profession.

What is the answer to this kind of

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MR. JACKSON: Do we have an accurate picture of the distribution of the medical profession throughout the country today, and if we made that examination, would we not find substantial pockets of people living in areas where they are separated by distances and examined that in regard to the medical profession today, I would say under a comprehensive, centralized plan, whatever it was, if the guarantee was there, with the government expenditure, that the services of the medical profession would be much more widely distributed in regard to the needs of the person than is the case today.

The tendency today is for a young student becoming a doctor to set up his business in an urban centre where he feels he will have the greatest possibility of earning a large income. I think, although I have no statistics to prove it, that there must be substantial areas in this country where there is substantial deficiency in the availability of medical services.

That, in my opinion, would be substantially reduced, if not entirely eliminated, under a comprehensive, centralized plan.

COMMISSIONER FIRESTONE: If I understood you correctly, you would envisage to tell doctors where to practise medicine?

MR. JACKSON: Not necessarily to tell but to offer the opportunities.

COMMISSIONER FIRESTONE: What form would the offer take?

MR. JACKSON: We have not attempted to blueprint the method of payment of the doctor, for instance, whether on a salary basis or fee basis, collected by the Government, but I think those facts would have to be gone into very thoroughly if one is interested today in making certain that every person requiring medical attention would get a medical practitioner, and the incentive to move into such areas would have to be looked at in terms of method of payment between the Government and the doctor; they are related.

COMMISSIONER FIRESTONE: As I understand you, your plan would envisage offering incentives for doctors to move to less densely-populated areas and part of the incentive may be financial, part of it may be facilities to practise, association with hospitals and so on.

MR. JACKSON: We are not attempting to blueprint the actual method of applying a comprehensive, centralized medical plan because that would require some substantial examination in terms of what is the need, and so on. Even one could argue that a flat salary applied would serve to fill many of these vacant areas because that would be higher than what a practitioner today could extract from that area. We are not proposing any particular blueprint in that respect.

COMMISSIONER FIRESTONE: I appreciate it and I do not feel we should ask you for the details of such a blueprint. But on the principle of asking people to go to areas you would offer incentives?

MR. JACKSON: I think under this system you would have to offer some incentive.

COMMISSIONER FIRESTONE: With regard to the dentists, we have been told that there are just not enough dentists in Canada, wherever you look, including many that are beyond the regular retirement age, to really take care of comprehensive health care services in the dental field, and how would you introduce such a plan if you haven't got the skilled manpower to do it?

MR. JACKSON: There again, isn't it for an incentive for the young student to take up dentistry?

COMMISSIONER FIRESTONE: You realize it takes a number of years to train people in the dental profession?

MR. JACKSON: Quite true.

COMMISSIONER FIRESTONE: And therefore would I be correct that you would be willing to go along with a program that would introduce comprehensive health care services in stages related to the supply of personnel to provide the services?

MR. JACKSON: Well, you are asking me what I would do if I were the Government in one sense. The Government has considerable power. I say again that the question is encouragement, and you can't move from one position of private enterprise, if you will, in the medical field, to a government, centralized government comprehensive plan in one step tomorrow; there is a grey area before your plan becomes operative

and provides all the benefits that are required.

But there are many fields that government can look at, not all in socialist countries, although there are some there, in terms of cost, to meet the needs of people in outlying areas, geographical distribution of people. They are all there; some of them in the capitalist countries, including Britain, Sweden and none of them would seem to us to argue in favour of the case of the C.M.A.

COMMISSIONER FIRESTONE: Do I understand you correctly, Mr. Jackson, that given the physical limitations in terms of facilities and given the manpower in developing a program, it may take us five or ten years to achieve what you consider an ideal objective?

MR. JACKSON: In a complete sense, yes.

COMMISSIONER FIRESTONE: And you go along with a program which may take five years to mature?

MR. JACKSON: Yes, if the ultimate is set out and some time limit is set.

COMMISSIONER FIRESTONE: And you would consider a five-year program a reasonable objective?

MR. JACKSON: I would say so, to be as complete as we call for.

COMMISSIONER FIRESTONE: If I may turn to page 3, sir, paragraph 5, sub-paragraph 1, and following up questions which the Chairman raised about a comprehensive health program for the Canadian people. I am just wondering, with the present situation of

and providing all the benefits that are required.

But there are many trade that government can look on, not all in socialist countries, although there are some there, in terms of cost, to meet the needs of people in outlying areas, geographical distribution of people. They are all there; some of them in the capitalist countries, including Britain, Sweden and none of them would seem to us to argue in favour of the case of the C.N.A.

CHAIRMAN (MR. SCOTCH). So I understand you correctly, Mr. Lecoon, that given the physical limitations in terms of facilities and given the manpower in developing a program, it may take five or ten years to achieve what you consider an

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MR. LECOON. [illegible]

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CONSTITUENCY DIRECTOR. If I may turn to page 4, sub-paragraph 5, sub-paragraph 1, and [illegible] the question with the chairman talking about a [illegible] with program 5 - the Canadian Council [illegible] Medicine, with the exact situation of

division of the present responsibility, if you would oppose such a program?

MR. JACKSON: We have no hard and fast position. I would think the guide lines would have to be set down by the Federal Government, administratively it could be apportioned.

COMMISSIONER FIRESTONE: You know in the field of hospital insurance this is how the program is in operation, it has developed this compromise within the division of responsibility. Would you find it acceptable to have a medical care program and other health care programs developed along the lines with the principle embodied in the hospital insurance plan?

MR. JACKSON: I would approach your question in this way: that I am not certain in my own mind that the Federal Government exhausted all its powers in the hospital field, prior to making it a proposition which a certain number of the provinces had to accept before it could be put into practice. I am still of the opinion that given the will by the Federal Government, the B.N.A. Act is not the obstacle it is made out to be in terms of federal responsibility. Therefore, I wouldn't think it would be necessary to be categorical from our point of view at this moment, pending meeting the problem of the B.N.A. Act.

The Federal Government did introduce a plan similar to that in the hospital field, of providing the funds but leaving administration to the hospitals.

division of our present responsibility, if you would propose such a program?

MR. [illegible]. We have no hard and fast position. I would think the guide lines would have to be set down by the Federal Government, administratively it could be a condition.

[illegible]. You know, in the field of hospital programs this is how the program [illegible] in operation, it has developed as a compromise within the division of responsibility. Would you find it acceptable to have a model care program and other health care programs developed along the lines [illegible] the concept as embodied in the [illegible] [illegible]?

MR. [illegible]. I would approach your question in this way. I am not certain in my own mind that the Federal Government explored all its avenues in the hospital field, prior to taking it a prescription which a certain number of the [illegible] had to accept before [illegible] practice. I am sure of the [illegible] that [illegible] the Federal Government, the [illegible] is [illegible] one [illegible] to [illegible] in terms of [illegible] responsibility. However, I wouldn't think [illegible] necessary to be determined [illegible] at the moment, depending upon the purpose of [illegible] Act.

[illegible] Federal Government [illegible] provide the funds [illegible] to the [illegible]

THE CHAIRMAN: You would have the Federal Government provide all funds?

MR. JACKSON: I would say yes, all funds, and also the guide lines, as in the hospital field, as to how the funds are to be spent.

COMMISSIONER FIRESTONE: As you know, in the hospital field the Federal Government's contribution is only 50%?

MR. JACKSON: We would prefer a federally-operated plan with the financial responsibility resting on the Federal Government. If it was necessary, because of the B.N.A. Act or other legislative restrictions, to share the administration, we would have no quarrel with that as an initial step.

COMMISSIONER FIRESTONE: How do you achieve a sense of responsibility if one level of responsibility supplies the money and another level spends it? It may be in the interests of Canada and be a more efficient system to have it 50-50.

MR. JACKSON: We would prefer to have complete federal responsibility. I would consider the other as a stop-gap to arrive at full application.

COMMISSIONER FIRESTONE: May I now turn to paragraph 7 on the same page, where you recommend that:

> "Drug prices should be drastically lowered and profiteering on the people's illness stopped by nationalizing drug manufacturing and operating needed enterprises as Crown

[illegible]: You would have the

[illegible] government [illegible] all funds?

[illegible]: I would say yes, all

funds, and also the public lands, as in the [illegible]

field [illegible] to how the funds are to be spent.

[illegible]: As you know,

in the present field the Federal Government's contri-

[illegible]

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bility supplies the money and another level spends it?

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[illegible] system to use it so-[illegible].

[illegible]: We would prefer to have

[illegible] flexibility. I would [illegible]

[illegible] as a stop-gap to begin at full employment

[illegible] programs. [illegible]

turn to [illegible] on the same [illegible] where [illegible]

[illegible]

[illegible] should be [illegible]

[illegible] and [illegible] of the

[illegible] [illegible]

[illegible] [illegible] and [illegible]

[illegible] [illegible]

companies."

Are you referring here to drug manufacturing in Canada?

MR. JACKSON: It would be manufacturing and distribution in the wholesale sense.

COMMISSIONER FIRESTONE: You are really reading my mind; I was going to raise the question: which way does distribution fit in in this paragraph, and you have said in the wholesale sense. How about retail distribution?

MR. JACKSON: No, we would not call for nationalization at the retail level, only at the manufacturing and wholesale level.

COMMISSIONER FIRESTONE: In other words, a State-operated agency or Crown company under the State would make these drugs available to retail distributors plus hospitals and other groups requiring them?

MR. JACKSON: Yes.

COMMISSIONER FIRESTONE: At cost, I presume?

MR. JACKSON: Whether cost or fixed price, plus other distribution costs.

MR. DURST: But with controlled prices at the retail level, it shouldn't give the individual druggist the opportunity to hike his prices up to the level they are today.

COMMISSIONER FIRESTONE: Well, I was just going to come to this question. Are you proposing - it is not mentioned in your brief and that is why I am

companies."

Are you referring here to duty manufacturing in Canada?

MR. JACKSON: It would be manufacturing and distribution in the wholesale sense.

COMMISSIONER FIRESTONE: You are really restating my point, I was going to raise the question: which way does distribution fit in in this "vacuum", and you have said in the wholesale sense.

MR. JACKSON: No, we would not call for nationalization at the retail level, only at the manufacturing and wholesale level.

COMMISSIONER FIRESTONE: In other words, a State-operated agency or Crown company under the State would make some rules available to retail distributors thus monopolists and other groups requiring

pressure?

MR. JACKSON: Whether cost or fixed price, plus other distribution costs.

MR. [illegible]: But with controlled prices at the retail level; it shouldn't give the individual "bugger" the opportunity to have his prices go to the level they are now.

COMMISSIONER FIRESTONE: Well, I was just going to come to this question. Are you suggesting it is not functional in very brief and terse is why I am

just wondering - are you proposing price-controlled drugs at the retail level?

MR. JACKSON: We would assume that would follow from the ---

COMMISSIONER FIRESTONE: Do you assume or do you recommend?

MR. JACKSON: We would recommend it. On that point, the Government of Norway sets the prices, sets a ceiling price for the retail trade on drugs and also sets a profit limit.

COMMISSIONER FIRESTONE: Thank you. If I may now turn to page 23. In paragraph 64 you speak of the medical expense of a family being $250 in 1961 or 6.5% of the manufacturing worker's total income.

MR. JACKSON: Yes.

COMMISSIONER FIRESTONE: Is there any implication in that 6.5% figure that the average worker cannot afford to pay $250 or 6.5 of his total income on what you call medical expense?

MR. JACKSON: I would say yes. If you examine a worker's budget based on what is shown here, I think you would find he is hard put to meet the normal cost of living. It depends on what you are using. You may find it is about 50% of what is required.

COMMISSIONER FIRESTONE: Do you feel that because there seems to be a large number of workers in this category which you refer to in paragraph 64, that is one of the reasons why you recommend a national medical care plan, compulsory and State-operated?

just wonderful - one you mentioning police controller
things at the [illegible] level.

Mr. [illegible]: We would assume that
would follow [illegible] --

[illegible]: Do you
agree or do you disagree?

At that point, the government of Ontario sets the pot and
sets a ceiling price for the rental trade on [illegible]
and also sets a percent limit.

If I may move to page 3. In paragraph 8 you
suggest the reduced workforce of a family [illegible]
in 1981 or 1982 or the manufacturing worker's total
income.

Mr. [illegible]: Yes.

[illegible]: Is there any
justification in that [illegible] that the average worker
cannot afford to pay [illegible] of his total income
on what you call [illegible]?

Mr. [illegible]: I would say yes. If you
examine a worker's budget based on what he shows now,
[illegible] you would find he [illegible] out to more than
normal cost of living. It depends on what you are
[illegible] may find it is about 1/3 of what [illegible]

[illegible] there seems to be a large number of workers
in this category [illegible] in [illegible],
that's one of the [illegible] you [illegible] a [illegible]
[illegible]

MR. JACKSON: There is more than one reason, but that is one of the compelling reasons, if you will, and with the application of the average, it can be very hefty in one case and very nominal in another.

THE CHAIRMAN: I suppose the basic reason is that you don't subscribe to the free enterprise system?

/ss

MR. JACKSON: Let us say we do not subscribe holus-bolus to the free enterprise system. We think it needs some doctoring in the form of some degree of nationalization in key sectors of the economy. You see the other side of the coin for these workers in trade unions is they negotiate with their employer for a portion of their wages to go to health in the form of insurance plans, medical plans and so on. It is very often an uneven application throughout the mass of the working people in this country and is robbing, if you will, part of the cash income, the increase in cash income the workers may be able to secure from the employers. We consider this is an area of Federal Government responsibility, not a responsibility of collective bargaining.

THE CHAIRMAN: This goes back to the first statement you made that health was primarily the responsibility of Government, the Federal Government.

MR. JACKSON: Right. I tied that in with the needs of the nation in terms of expansion of gross national product and the requirements of productivity. These are all inter-related and as such we say except G.N.P. it is the responsibility to provide environment, atmosphere and the necessary administration.

THE CHAIRMAN: I am just rounding out your approach, and that is why you say it should be the Federal Government that should pay the total bill.

MR. JACKSON: Right.

COMMISSIONER FIRESTONE: Mr. Jackson, a little earlier this afternoon we had before us the Ontario Chamber of Commerce. They made the point that

[illegible] Let us say we do not
succumb to those [illegible] the free enterprise system,
we think it does some doctoring in the form of some
[illegible] or nationalization in key sectors of the economy
[illegible] the other side of the coin for these workers in
these unions is their negotiate with their employer for a
portion of their wages to go to health in the form of
insurance plans, medical plans and so on. It is very
often an uneven application throughout the mass of the
working people in this country and is robbing, if you
will, part of the gain [illegible], the increase in real
income the workers may be able to secure from the employers.
We consider this is a strong Federal Government responsibility, not a responsibility of collective bargaining.

[illegible] This goes back to the
first question you made that health was primarily the
responsibility of government, the Federal Government.

[illegible] I did that in
[illegible] the needs of the nation in terms of expansion of
[illegible] national [illegible] and the requirements of productivity.
[illegible] are all [illegible] as soon as we say except
[illegible] it is the [illegible] ability to provide environment,
[illegible] and [illegible] modernization.

[illegible] I am then [illegible]
[illegible], in that in my view any [illegible] the
[illegible] Congress [illegible] [illegible] the [illegible]
[illegible]

[illegible]

[illegible] [illegible] [illegible] [illegible]
[illegible] [illegible] [illegible] [illegible] [illegible] [illegible] that

in their view based on experience they have had in the Province of Ontario the majority of people in Ontario are able to take care of their own health expenditures and that the people that were really in need was a minority group.

MR. JACKSON: How did they prove that point?

THE CHAIRMAN: They said actually they were covered by some form of prepayment agreement, prepayment plans.

MR. JACKSON: Did the Chamber go into the examination of averaging out the various types of plans that people are covered by in this Province. I think if they did that, they would be put to the proof of their statement as to working people being adequately covered. We don't believe from our examination they are.

COMMISSIONER FIRESTONE: What evidence have you to support your observation?

MR. JACKSON: We have some 65 different contracts with different corporations. There is no common denominator in terms of the extent of medical and hospital coverage. It varies from plant to plant, depending on the bargaining situation in each plant. In none is it comprehensive, in none. There is a levy in addition to the premium. Some companies pay the whole premium. Some pay half, some pay a quarter, but in almost every case I would say in every case there is still a residue of cost the worker has to meet above what is covered under these plans. I would certainly ask the Chamber of Commerce to prove their point with some statistics of the extent of

in their view based on experience they have had in the Province of Ontario the security of people in insurance are able to take care of their own with expenditures and that the people that were really in need was a minority group.

[illegible]

THE CHAIRMAN: They could actually they were covered by some form of insurance agreement, prepayment plans.

[illegible] and the Member go into the exploration of covering out the various types of cases that people are covered by in the Province. I think if they did that, they would be put to the proof of their statement as to working people being adequately covered. We don't believe from our examination they are [illegible] that evidence have you to support your statement.

[illegible] We have some 15 different contracts with different companies. There is no common denominator in terms of the extent of medical and hospital coverage. It varies from plant to plant, depending on the bargaining strength in each plant. In some is it comprehensive, in some there is a levy in addition to the premium. There coverage by the whole province, [illegible], some not a premium, but in almost every case I would say in every case there is still a residue of cost the worker has to pay [illegible] not is covered under their plans. I would certainly ask the Member or Members to raise their point with some witnesses or the [illegible] of

coverage and how well people are covered in these programs. The fact there are a substantial number or substantial percentage....

THE CHAIRMAN: We have had figures, not from that brief, but from several others showing the various categories of coverage including this.

MR. DURST: In my own personal plant the company pays half of P.S.I., but now we find, I found this from personal experience when we call a doctor this is taken care of through P.S.I., but he prescribes a drug for $10.00, $12.00, $20.00, and the average worker who is raising a family finds that cuts down part of the groceries, you see, and while the doctor's visit is taken care of, or in the case of need, an operation, but there again in our case the price of drugs adds up a good deal to it. I for one have known a number of people personally who have lost everything they worked and saved for through some illness. I cannot myself see there is any justification in a system where a person can lose their life-savings through some kind of illness that is no fault of theirs, or whether it be their own fault. Those of us who are directly associated with working people, we see these things all the time and this is one of the reasons why we feel so strongly for socialized medicine.

THE CHAIRMAN: That is what you want, socialized medicine.

MR. JACKSON: They put tabs on everything. We call it comprehensive.

THE CHAIRMAN: So the people on the street can understand it.

MR. JACKSON: It is an impression a lot of people carry. I wouldn't accept that label to this plan. It is a comprehensive plan paid for by the Federal Government. That is not socialization.

COMMISSIONER FIRESTONE: Mr. Jackson, one point that has been put to us has been something like 60% of the Canadian population are being covered by various plans, medically-sponsored or commercial plans, and the proportion continues to rise with the expectation that perhaps, 70, 75% may be covered in the next few years. Why should there be a State-operated plan compulsory for all introduced to take care of just a minority? That is an argument that has been put up to us, why a national plan should take care of a minority when the coverage has already been able to take care of those in what they apparently consider are adequate plans, otherwise they wouldn't be paying for such plans.

MR. JACKSON: The plans they are receiving is what they feel they can afford to pay for. It doesn't necessarily give them what we are looking for, or what they desire, namely complete health coverage and the treatments, preventive and curative.

COMMISSIONER FIRESTONE: In other words, you feel that the existing system is not comprehensive enough and not adequate enough and the only way to achieve comprehensiveness, adequacy and universality is through the plan you proposed.

MR. JACKSON: Plus equality of distribution of costs through taxation.

COMMISSIONER FIRESTONE: Which, in fact,

[illegible] It is an impression a lot of people [illegible]. I don't accept that idea of this plan. It is a [illegible] comprehensive plan paid for by the general [illegible]. That is not [illegible]

One point that has been put to us has been something like 30% of the [illegible] people are being covered by various plans, [illegible] commercial plans, and the [illegible] conditions [illegible] with the expectation that perhaps, [illegible] in the next few years, [illegible] there be a [illegible] plan necessary [illegible] to take care of that a minority. That is an argument that has been put up to us, why a national plan should take care of a minority when the coverage has already been able to take care of those [illegible] they are [illegible] are adequate plans, otherwise they wouldn't be paying for such plans.

[illegible] the plans they are receiving is what they can afford to pay for. It doesn't necessarily give them what we are looking for, or what they [illegible] coverage [illegible] the [illegible], [illegible] and [illegible].

[illegible] In other words, you know that the existing system is not [illegible] and [illegible] the only way to achieve [illegible] adequacy and universality is through the [illegible]

[illegible]

[illegible] In fact

is really a means of redistributing income.

MR.JACKSON: We make the point on a taxation basis as a source of increasing the general revenue of the country.

COMMISSIONER FIRESTONE: Which is a redistribution of income, those in the high income pay more and the lower pay less or nothing.

MR. JACKSON: Our definition of a certain minimum of decency in health as a standard for the Canadian people with a guarantee by Government that is the minimum.

COMMISSIONER FIRESTONE: Have you any suggestions of what is the desirable minimum?

MR. JACKSON: Cash-wise?

COMMISSIONER FIRESTONE: Any way you wish.

MR. JACKSON: I say that we have no standard --- no objectives established in Canada. We did have at one time established by the Ontario Welfare -- the Toronto Welfare, I think it was, which was used as a criterion for argumentation as to living standards. The only budget that stands out today in the North American Continent is the Heller Budget which places $6,500.00 to $6,800.00 as the minimum of health and decency. The Bureau of Labour Standards apply some of the American studies and transpose it into Canadian costs which would be about $500.00 to $700.00 less than that figure. The average wages in this country don't come near it at all. They are substantially below every one of those figures.

COMMISSIONER FIRESTONE: Thank you very much.

it would be a means of redistributing income.

MR. MACLEOD: We made the point on a taxation basis as a scheme of increasing the general revenue of the country.

COMMISSIONER FISHER: Which is a redistribution of income, those in the high income pay more and the lower pay less or nothing.

[illegible]

certain minimum of decency it involves a standard for the Canadian people with a guarantee by Government that is the minimum.

COMMISSIONER FISHER: Have you any suggestions of what is the minimum income.

MR. [illegible]: [illegible].

THE PRESIDING COMMISSIONER: Any way you wish.

MR. [illegible]: I say that we have no standard --- no objectives established in Canada as [illegible] have at any time established by the [illegible] Welfare -- the Toronto Welfare, I think it was, which was used as a [illegible] for [illegible] living standards. The only budget that [illegible] the North American continent is the [illegible] which places $4,000 or $5,000 as the minimum of health and decency. [illegible] [illegible] [illegible] the [illegible] [illegible] [illegible] [illegible] which would [illegible] more than that figure. [illegible] [illegible] [illegible] [illegible] [illegible] those figures [illegible]

COMMISSIONER VAN WART: Are you familiar with the H.I.P. plan in New York?

MR. JACKSON: No, I am afraid I am not. Is that a municipal plan?

COMMISSIONER VAN WART: No, it is an insurance plan, 7,000,000 labour people.

THE CHAIRMAN: 1,000,000.

COMMISSIONER VAN WART: I am sorry, 1,000,000.

MR. JACKSON: Operated by group unions. I don't know it specifically, no.

THE CHAIRMAN: Very well, Mr. Jackson. Thank you for your attendance here, for your brief and your willingness to discuss the matter with us.

MR. JACKSON: Thank you for your interest.

THE SECRETARY: The next submission will be that of the Canadian Association of Occupational Therapy, which will be known as Exhibit 309. Mrs. Smith will introduce the delegation.

MRS. ANNA VAN ARKIT. Are you [illegible]

in the [illegible] [illegible] room [illegible]

[illegible] No, I am afraid I am not.

[illegible] [illegible]

[illegible] No, it is

[illegible] [illegible] [illegible] [illegible]

CONSTABLE VAN ARKIT. I am sorry,

[illegible]

MR. MACKEN. Governed by group unions.

I don't know it exactly, no.

Thank you for attending here, as your duties and your willingness to assist the authorities.

MRS. ARKIT. Thank you for your interest.

[illegible] The next witness will be Chief of the Central Association of Cooperatives, Theodore, which will be known as Mr. [illegible]. Mr. Smith [illegible] introduce the witness.

SUBMISSION OF
THE CANADIAN ASSOCIATION OF OCCUPATIONAL THERAPY

---EXHIBIT NO. 309: Submission of the Canadian Association of Occupational Therapy.

APPEARANCES:

DR. J.N. SWANSON,
DR. B.H.G. CURRY,
MRS. M.T. CARDWELL,
MRS. L.C. SMITH,
MISS M. LANGLEY,
MISS H. JENSEN.

MRS. SMITH: Mr. Justice Hall and Members of the Royal Commission, I would like to present my colleagues to you. On my far right is Miss Margaret Langley, who is an adviser to Committee on Psychiatric Service; Dr. Curry, who is Vice-President of our Association and is advising today on medical matters; Mrs. Thelma Cardwell, who is Vice-President of the Association and will be advising on educational matters; on my left Dr. J. Swanson, who is President of our Association and Adviser on Medical Matters and on my far left Miss Helen Jensen, who will advise on matters pertaining to physical disabilities.

It is my privilege along with my colleagues to present the brief submitted by the Canadian Association of Occupational Therapy. It is assumed the Commissioners have had the opportunity to review the full content of our submission as it was laid down in the prescribed form. In speaking to the brief it is our wish

gentlemen, to follow the material under the headings of introduction, conclusion and recommendations and to elucidate certain sections by very brief reference to the supporting material. We would like to do this in a somewhat informal manner if you will so allow.

As you know, the occupational therapist is one of the paramedical personnel recognized as essential in the team of specialists whose responsibility is the rehabilitation of the physically and mentally disabled. The contribution which can be made is directly related to the quality and quantity of personnel. For many years the supply of occupational therapists has been greatly less than demand. This has had an adverse effect upon the quality of service which must be made available if the disabled are to be re-established as functioning members of our society. We emphasize functioning, as this is the area in which occupational therapy makes its greatest contribution.

In reference to the shortage of personnel, I would draw your attention to the statement on page 1, paragraph 4, that 656 additional occupational therapists are required to staff present established facilities. This means that many services are operating far below the required complement of staff and that many hospitals with facilities for occupational therapy have no therapist to use those facilities. With only 319 occupational therapists employed in the treatment of patients throughout Canada, the present shortage, in reference only to services with occupational therapy departments, is more than double the number employed.

gentlemen, to follow the material under the headings of introduction, conclusion and recommendations and to elucidate certain sections by very brief reference to the supporting material. We would like to do this in a [illegible] informal manner if you will so allow.

As you know, the occupational therapist is one of the paramedical personnel recognized as essential in the team of specialists whose responsibility is the rehabilitation of the physically and mentally disabled. The contribution which can be made is directly related to the quality and quantity of personnel. For many years the supply of occupational therapists has been greatly less than demand. This has had an adverse effect upon the quality of service which must be made available if the disabled are to be re-established as functioning members of our society. We emphasize functioning, as this is the area in which occupational therapy makes its greatest contribution.

In reference to the shortage of personnel, I would draw your attention to the statement on page 1, paragraph 4, that 648 additional occupational therapists are required to staff present establishment facilities. This means that many services are operating far below the required complement of staff and that many hospitals with facilities for occupational therapy have to be thought to use these facilities. With only 148 occupational therapists employed in the treatment of patients throughout Canada, the present shortage, in proportion to services with occupational therapy departments, is more than double the number employed.

When one considers the number of new departments in rehabilitation centres, and hospitals which have no occupational therapy facilities, the shortage becomes almost double again, and obviously cannot be alleviated without the early implementation of action to resolve the situation. Our recommendations, therefore, deal mainly with suggested methods of increasing the quantity in the shortest possible time, without sacrificing quality. This involves the establishment of additional schools, with basic courses in occupational therapy which meet the minimum standards --- two academic years with six months of practical experience in addition. It is from this basic course that we recommend that provision be made for advanced education to prepare a more limited number of therapists for positions of supervisory, teaching and specialists responsibilities.

It is also our contention that adjustments in curriculum, increased salaries would attract more students and in particular male students whose years of service can be expected to greatly exceed that of the female graduate.

To acquaint prospective students with occupational therapy as a health service career, a greatly increased publicity campaign should be initiated at national, provincial and local levels. The Association recognizes its own responsibility in this regard but would appreciate increased assistance from the federal and provincial publicity authority.

There is evidence that many students who wish to become therapists are unable to finance their

When one considers the number of new

registrants in rehabilitation centres, and recognizes [illegible]

[illegible]

become [illegible] during [illegible] years, and obviously cannot be

expedited without the early implementation of action to

meet the situation. Our recommendations, therefore,

[illegible]

[illegible], in the shortest possible time, without sacrificing

[illegible]. This involves the [illegible] amount of additional

[illegible], with need [illegible] functional training

[illegible] meet the minimum standards --- two or three years

[illegible] of practical experience [illegible]

[illegible]

provision be made for advanced education to prepare a more

limited number of therapists for positions of supervisory,

teaching and specialists responsibilities.

It is also our contention that adjust-

ments in [illegible], increased [illegible]

students and in particular male students [illegible] years of

service can be expected to greatly assist [illegible] the

[illegible] problem.

[illegible]

[illegible]

[illegible]

recognizes its own responsibility in this matter and would

appreciate [illegible]

[illegible]

[illegible] is [illegible]

[illegible]

education beyond high school. It is recommended that grants, bursaries, and scholarships be made available to this group. Financial assistance is also necessary to enable graduate therapists to undertake post-graduate education in special fields of service, in administration and in teaching. To develop more schools, teachers must be prepared and this requires a greater outlay of funds than many therapists are able to accumulate from present salaries.

In order to make the most efficient use of occupational therapy facilities, it is recommended that medical students and members of medical associations be provided with more information as to current rehabilitation procedures with emphasis on the role of the para-medical professions which, of course, include occupational therapy.

There is also need for standards to be established for the physical facilities and programs of occupational therapy in specific fields of service. This can be most adequately accomplished by seeking the collaboration of the Associaton or of occupational therapists whose experience qualifies them to give expert assistance. Advisory committees on rehabilitation of the handicapped would be strengthened if the opinions of the professional organizations representing the para-medical groups were considered.

education beyond high school. It is recommended that grants, research, and scholarships be available to this group. Research should be also necessary to evaluate the material to determine a post-graduate course in special fields of science, in administration and in teaching. To develop more schools, teachers must be encouraged and there is need for graduate study at times from many therapists who are to graduate from universities and colleges.

In order to make the most efficient use of a national training facilities, it is recommended that the first priorities in measures of medical assistance be provided with more intensive attention as to current capabilities, more use with a medium to point of the pure-medical professions until, of course, training occupational therapy [illegible] is also need for students to be established for the physical facilities and programs of occupational therapy in medical fields of service. This can be most clearly accomplished by seeking the cooperation of the Association or of occupational therapists whose experience can direct them to give expert assistance. Matters concerned on modification of the handicapped would be strengthened if the organization of professional associations supporting the occupational therapy were considered.

We presented a somewhat condensed version of our recommendations, which you have before you in a much more formal manner, and we are now prepared to enlarge on any section of it as suits your pleasure.

THE CHAIRMAN: Thank you very much, Mrs. Smith. This is one of the areas where the shortage is so great that it is something like the supply of dentists. It is rather difficult to see just where you start at all.

COMMISSIONER GIRARD: Mrs. Smith, because of this shortage of occupational therapists that you have mentioned, I notice in your brief that you are planning a two-year course. I presume this is because of the shortage, the basic two-year course, is that right?

MRS. SMITH: We are not planning one, we have suggested that a basic two-year course would be adequate to qualify.

COMMISSIONER GIRARD: You recommend a basic two-year course?

MRS. SMITH: Yes.

COMMISSIONER GIRARD: But you also have a special course sponsored by your Association that is an 18-month course?

MRS. SMITH: That is right.

COMMISSIONER GIRARD: What would be the difference between these two courses, or would this special course disappear, or would they be ---

MRS. SMITH: No, the special course is

[illegible] I [illegible] [illegible]

[illegible] of the recommendations, which you have before you is a [illegible] one [illegible] manner, and we are [illegible] prepared to endorse or [illegible] it as quite [illegible] [illegible].

THE CHAIRMAN. Thank you very much, [illegible] Smith. This is one of the areas where the [illegible] is so great that [illegible] scrutiny [illegible] [illegible] of dentists. [illegible] [illegible] [illegible] to see [illegible] [illegible] [illegible] at all.

[illegible] Smith, [illegible] of this [illegible] or occupational therapists that you have [illegible]. I notice in your brief [illegible] you are [illegible] [illegible] [illegible]. I presume this is because of the [illegible] the [illegible] [illegible] is that right?

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

planned for people with an advanced education and previous professional training, and it is felt that they are able to absorb the necessary knowledge in a faster period of time. The people who are admitted to that course must have a university degree, a diploma, qualifications in nursing, or in teaching. The two-year course which I suggested also has an additional six months, which makes it two and a half years, rather than two years. The six months being practical experience, which is after all part and parcel of general education.

THE CHAIRMAN: Clinical experience?

MRS. SMITH: That is right.

COMMISSIONER GIRARD: Then there is a trend, some universities are planning to, instead of having the three-year course and ending up with preparing physiotherapists and occupational therapists, they are, after the second year, dividing, and preparing either one or the other. Would this be helpful in alleviating the shortage of occupational therapists?

MRS. SMITH: Well, it still is a greater length of time, because under the present system of combined training, in addition to the three years academic work at the universities, there is another seven months of clinical internment, which makes it the equivalent of four academic years actually, so that the other would reduce it by somewhere near a year and a half in getting people out more quickly.

COMMISSIONER GIRARD: You mean the two-year course?

MRS. SMITH: Yes, with the six months.

COMMISSIONER GIRARD: Well then, what is the idea of this other one? What are the benefits that will accrue to occupational therapists by being vocational at the third year? The trend now is at the end of the second year to split, and have occupational or physiotherapists. What will be the advantages of this?

MRS. SMITH: This is not really the trend across the whole country. We are getting to the place now where there are hardly two schools presenting the same curriculum in the same length of time.

For example, the University of Montreal, as you may have heard when we presented the brief in Quebec, is changing from a three-year combined course to separate two-year courses. McGill University has a combined year, and then the students specialize in the next year. The University of Toronto is combined throughout. The University of Manitoba enrols girls into a two-year course in separate diplomas. The University of Alberta gives them two years combined, and then separates in the third year. The University of British Columbia is combined for two years, and this requires one year of clinical practice in addition, so that we cannot say that there is any special trend that is going to -- although the one indication is that the trend to combined training is not continuing. There is more separation.

COMMISSIONER GIRARD: What are your chances of getting more male occupational therapists, to alleviate the shortages again?

[illegible]

[illegible]

[illegible]

MRS. SMITH: Well, the only experience we have on which to base this is our own special course in Kingston, which has graduated the first male students to be graduated in Canada, and when the present class is finished we will have graduated eight male students. We are presently enrolling students for 1962, and we have at this moment five applicants from male students.

You see, up until fairly recently the universities didn't admit male students to training.

THE CHAIRMAN: Are you able to foresee sufficient income for the male to justify, to attract more into that field?

MRS. SMITH: I think this will attract a certain group of male students. Many of the ones we have now are men who have taken nursing, perhaps in England or some other country, and feel that they would like to ---

THE CHAIRMAN: There is a logical ---

MRS. SMITH: Yes, there is a logical connection, rehabilitation.

THE CHAIRMAN: Is there a differentiation of income between the male graduate and the female graduate?

MRS. SMITH. No.

THE CHAIRMAN: Once they go into therapy work in one of the institutions?

MRS. SMITH: No. The only thing is that the male student stays long enough to take advantage of the higher salaries and they go into administrative positions.

COMMISSIONER FIRESTONE: You are losing the men if they move into administrative positions as therapists?

MRS. SMITH: But you have always them in the departments.

COMMISSIONER GIRARD: On page 6, paragraph 14, insofar as the correlation of all health services, you say here:

"In respect to occupational therapy in particular, the service must be correlated with other rehabilitation services in hospitals, rehabilitation

a certain group of men, strangers. Many of the men we have now are men who, we take, learning, perhaps in England or some other country, and feel that they would like to --

[illegible]. There is a logical --

[illegible] There is a legend

connection, perhaps, between

The [illegible] is trying a differentiation of groups, giving the male pre-eminence and the female

[illegible]

[illegible] Are you go to make

the very work in use of the institution?

[illegible] The only thing is

that the male students have some groups to take advantage of the bright [illegible], and they go into administrative positions.

[illegible] You are losing

the men if they have some administrative positions as

[illegible]

[illegible] But you have always them

in the department.

[illegible] GRAHAM. On page 4,

[illegible] in the consolidation of all capital

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

centres, other institutions and home care programs."

Would you like to clarify this for my information? My impression is that occupational therapists are always working in departments or rehabilitation services or rehabilitation centres. Would you have occupational therapists working alone and not in correlation with rehabilitation centres?

MRS. SMITH: But there are circumstances where the various disciplines making up the para-medical services are not well-co-ordinated in hospitals. There are situations of that kind. We also refer to home care programs where they could be out in the district. They are well-correlated in rehabilitation centres but there are some hospitals in which they are not well-correlated.

COMMISSIONER FIRESTONE: Mrs. Smith, may we turn to page 3, paragraph (b), sub-paragraph (i), in which you recommend financial assistance in the form of grants, bursaries and/or scholarships be made available to students in undergraduate courses, and fellowships for advanced education in such specialties as psychiatry, orthopaedics, administration and teaching. Have you any suggestions, Mrs. Smith, on what you would consider an adequate scholarship for a year at the undergraduate level and, secondly, at the graduate level?

MRS. SMITH: Mr. Firestone, you remember we were asked this question at the Quebec Society and prepared an addenda for you which was attached to our brief.

THE CHAIRMAN: Yes, it is here.

MRS. SMITH: Does it answer your question, Mr. Firestone?

COMMISSIONER FIRESTONE: I see here that you are referring to a sum of $300,000 to be allotted to provide two hundred $1,500 bursaries in the first year. Are these bursaries for undergraduate or graduate students?

MRS. SMITH: Undergraduate.

COMMISSIONER FIRESTONE: And at the present level you are suggesting that the sum of $25,000 be made available?

MRS. SMITH: Yes.

COMMISSIONER FIRESTONE: And the amounts that are suggested are $1,200, $2,400 and $3,600, also plus travelling expenses?

MRS. SMITH: That is correct.

COMMISSIONER FIRESTONE: Now, if 200 bursaries were made available, is there an adequate number of worthy applicants to make use of these bursaries?

MRS. SMITH: Well, Mr. Firestone, the figure 200 was based on information which we obtained as to a suggested need. We contacted the University of Toronto, contacted the Department of National Health Grants and from correspondence in our own office we found in the past year there had been 75 enquiries about bursary support from students at the University of Toronto.

Now, that represents roughly one-third of the total number of students enrolled at the university, and in estimating the possible enrolment for 1962-63

in all the schools of the country, we came up with a figure of around 625 students, so we assumed that a third would be 200.

COMMISSIONER FIRESTONE: You would feel that the availability of these bursaries would increase the supply of students materially, because you are not just interested in the financing only, you are also trying to use this as a device to attract more young people into the field?

MRS. SMITH: Yes, and also using it to attract the right type of young people. There are many young people who have a very high academic standing who cannot afford to enroll and from the enquiries we have got, the students are interested but they haven't got the money and they go into something else.

THE CHAIRMAN: Do you find any hesitation in the enquiries about the conditional aspect of having to ---

MRS. SMITH: That we have suggested here?

THE CHAIRMAN: Yes.

MRS. SMITH: Of course, this has never been tried with undergraduate students; I don't think so as far as we are concerned. There are some of the provinces that do offer bursaries with return in service, but there are very few, and this, of course, is the student's choice.

For instance, they either work it out or buy it out if they wish. I feel a great many of the

Smith: Lines

in all the schools of the country, we are up with a figure of around 25 students, so we assume that a third would be 400.

Best that the availability of these buses would increase the supply of students naturally, because you are not just interested in the figures only, you are also trying to use this as a device to attract more young people into the [illegible]

MR. SMITH: Yes, and also using it to attract the right type of young people. There are many young people who have a very high academic standing who cannot afford to enroll and [illegible] the courses we have [illegible], but students are [illegible] but they haven't got the money and they do not [illegible]

MR. CHAIRMAN: Do you find any resistation in the surrounds about the [illegible] assets of [illegible] to ---

MR. SMITH: [illegible]

[illegible]

MR. [illegible]: [illegible] has been tried with [illegible] students, I don't think so as far as [illegible] [illegible]. There are some of the provinces that [illegible] [illegible] [illegible] [illegible], but there are [illegible] and this, of course, is the student's [illegible]

[illegible], [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible]

students, if they had assistance for the first year, could probably assist themselves in their second and third years. It is getting started, and when they are doing intern work they are in the hospital and at that time they receive an honorarium, although it is not enough to provide for them in the first year but it is enough to get them started.

There are also loans by the universities for a student who has completed one year and can't continue.

So if the funds were available we could probably keep them going.

THE CHAIRMAN: In regard to the suggestion of additional courses at Dalhousie, Saskatchewan, have any overtures, approaches, been made to the Schools of Medicine at either place to see if these additional courses might be inaugurated?

MRS. SMITH: We have had correspondence with the University of Saskatchewan; we have had no direct correspondence with Dalhousie. I have discussed the matter with various doctors on the staff of the University, Faculty of Medicine, at Dalhousie, and at the last conversation they were discussing some plan where there might be a four-Maritime Province promotion for a school.

They feel that each one is probably too small, but if there could be a four-way support of such a school this might best be accomplished, and I believe they are giving it earnest consideration.

THE CHAIRMAN: I suppose the idea of

a school in the section not now served also makes it easier to recruit?

MRS. SMITH: Yes.

THE CHAIRMAN: For instance, in the whole of the Atlantic situation now?

MRS. SMITH: Yes, and you find once you have a school in the area your services develop, in the hospital, because they have a continuing supply of personnel.

THE CHAIRMAN: Are there any other observations or explanations you would like to make, Mrs. Smith, or any of your associates here? You know, as we discuss the thing, some ideas occur and they are sort of lost unless we develop it right at the time.

COMMISSIONER GIRARD: May I ask one more question in regard to female students? Why do you think you have to attract male students in your special course and you haven't had to in your other courses? Was it because it was a shorter course?

MRS. SMITH: I don't know what the reason is. Our students come to us in rather a different way than the students come to the universities. Again, we have been fortunate in that our course has been approved for federal and provincial grants to support it, and also bursaries have been made available for students to take the course, and under the provincial regulations the student must be sponsored by a hospital.

Therefore, many of the hospitals have found a likely candidate that they want to send for

a school in this section not now served also make it easier to recruit?

THE CHAIRMAN. For instance, in the whole of the Atlantic situation now?

MRS. SMITH. Yes, and you find once you have a school in the area your services develop in the hospital, because they have a continuing supply of personnel.

THE CHAIRMAN. Are there any other observations or explanations you would like to make, Mrs. Smith, or any of your associates here? You know, as we discuss the thing, some jobs occur and they are sent or lost unless we develop it right at the time.

COMMISSIONER CLARK. May I ask one more question in regard to female students? Why do you think you have to attract male students in your special courses and you haven't had to in your other courses? Was it because it was a shorter course?

MRS. SMITH. I don't know what the reason is. Our students come to us in matter a different way than the students come to the universities. Again, we have been fortunate in that our courses have been approved for federal aid providing an incentive to support it, and also fellowships have been made available for students to take the course, and under the provisional regulations the students must be sponsored by a [illegible].

However, many of the hospitals have found a likely candidate that they want to send for

training to come back to them to work in their occupational therapy department. So, these men have been selected by their sponsoring hospital to take the course.

COMMISSIONER GIRARD: But they might have got that bursary in the same way from the other courses?

MRS. SMITH: Another thing, our students are older than the university students; some are in their late 30's and not admissible to the university courses.

COMMISSIONER GIRARD: It is to get your idea how to go about getting them. Thank you very much.

THE CHAIRMAN: This recommended salary scale in Appendix D - you may have said so - what is the difference in the range of this recommended scale from the present scale?

MRS. SMITH: Well, the present scale now averages a starting salary of about $3,600.

THE CHAIRMAN: About 10%?

MRS. SMITH: About 10%.

THE CHAIRMAN: And you have to negotiate this, I suppose, at the various places? Is there any indication this may be accepted?

MRS. SMITH: We don't expect it to be accepted the year it comes out, ever, but we find whenever a scale comes out there is a general upgrading. One or two institutions have accepted the scale at the present time. They are institutions which employ a

training to come back to them to work in their occupational therapy department. So, these men have been selected by their commanding officers to take the course.

CONDIMENTOWER [illegible]: But they might have not that message in the same way from the other veterans?

MRS. SMITH: Another thing, our students are older than the university students, some are in their late 40's and not adaptable to the [illegible]

CONDIMENTOWER [illegible]: It is to get your idea how to go about doing it. Just [illegible] your work.

[illegible]

SALARY SCALE IN A-DEPT'L D - You may have said so. What is the difference in the range of the recommended salary from the present scale?

MRS. SMITH: Well, the present [illegible] an average [illegible] scale [illegible] $[illegible].

[illegible]

[illegible]: Anyone have [illegible] this, I suppose, at the various [illegible]? Is there any indication this may be accepted?

MRS. SMITH: We don't expect it to be accepted the year [illegible], but we find whenever a girl comes our [illegible] [illegible] on the [illegible] [illegible] present time. [illegible]

large number of therapists, and I think it will have some influence on other institutions in those particular areas.

B/hm

THE CHAIRMAN: I suppose ultimately the adoption of a proper wage-scale is probably the best thing you could do for improving?

DR. SWANSON: I would like to make one comment on Appendix B chart 5 the bottom of page B3. There are some figures, which I am sure you read, but the full significance of them may not have been appreciated. Employed in January of 1957 were 216 Canadian graduates and employed in December of 1961 were 218, which represents a growth of two in five academic years. This is a very difficult thing to explain.

THE CHAIRMAN: Unless marriage is the answer.

DR. SWANSON: It may be, but I think the point is there has been a very great upsurge of interest in physical medicine and physiotherapy and all doctors have been very interested in physiotherapists, not as interested in the occupational aspects of rehabilitation as we ought to have been. This leads into areas it is not easy to talk about. I think it should be known the science and art of occupational therapy has not been recognized. One hears more about physiotherapy and less about occupational therapy. One in the field of arthritis and other fields ....

THE CHAIRMAN: The medical profession may have to take part of the blame?

DR. SWANSON: I think so. I think it is very true. It is very hard to convince some of the members of the profession because they can see quick results of exercise of muscles and they fail to

THE CHAIRMAN: I suppose ultimately the question of a course of procedure is probably the most thing you could do for improvement?

Mr. [illegible]: I would like to make one comment on [illegible] chart 5 the bottom of page [illegible]. There are some figures, which I am sure you read, but the full [illegible] figures of them may not have been [illegible]. Admitted in January of 1957 were 715 [illegible] patients and employed in December of 1961 were [illegible], which represents a growth of two in five academic years. This is a very difficult thing to explain.

Dr. [illegible]: THE CHAIRMAN: Unless anybody is [illegible] a question.

Dr. [illegible]: It may be, but I think the point is there has been a very great measure of interest in physical medicine and physiotherapy and [illegible] doctors have been very interested in physiotherapists not as interested in the occupational aspects of rehabilitation as we built to have been. This leads into areas it is not easy to talk about. I think we should be known the [illegible] and art or occupational therapy has not been mentioned. One hears more about [illegible] and less about occupational therapy. [illegible] in the field of [illegible] and other [illegible].

THE CHAIRMAN: The medical profession may have to take part of the blame.

Mr. [illegible]: I think so. I think it is very true. It is [illegible] to consider some of the reasons of the [illegible] in [illegible] they [illegible] some [illegible] results of [illegible] of [illegible] and they fail to

see over a long term in a chronic program it is what you do with the muscle. You have to retrain and exercise and this takes a lot of time and patience and in certain aspects rehabilitation needs more occupational than physiotherapy. This is not to decry in any way physiotherapy but to cry more on behalf of occupational.

THE CHAIRMAN: Thank you very much Miss Smith and your associates. We are getting around to what has now come to be a long day. We are grateful to you for your brief and the help you have given us and the additional information which we asked for and which has now been furnished. Thank you very much.

We will adjourn until 9:30 tomorrow morning.

---ADJOURNMENT.

ROYAL COMMISSION ON HEALTH SERVICES

HEARINGS

HELD AT

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ROYAL COMMISSION ON HEALTH SERVICES

Proceedings of the hearings
held in Toronto, Ontario,
on the 24th day of May, 1962.

COMMISSION MEMBERS:

Chief Justice EMMETT M. HALL -- Chairman

Miss ALICE GIRARD, R.N.

Dr. C.J. STRACHAN

Dr. ARTHUR F. VAN WART

Mr. M. WALLACE McCUTCHEON, Q.C.

Prof. O.J. FIRESTONE

Dr. DAVID M. BALTZAN

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MEDICAL CONSULTANT:

Dr. PIERRE JOBIN

DIRECTOR OF RESEARCH:

Prof. BERNARD BLISHEN

COMMISSION SECRETARY:

Mr. N. LAFRANCE

Toronto, Ontario,
Thursday, 24th May, 1962.

.G/dpw

--- On commencing at 9.30 a.m.

THE SECRETARY: Mr. Chairman, the first submission this morning is from the Canadian Council for Crippled Children and Adults, to be known as Exhibit 310, and Dr. Armstrong will introduce his group to the Commission and present his recommendations.

--- EXHIBIT NO. 310: Submission of the Canadian Council for Crippled Children and Adults.

SUBMISSION OF THE CANADIAN COUNCIL FOR CRIPPLED CHILDREN AND ADULTS

Appearances: Dr. Keith S. Armstrong
Dr. Ralph Struthers
Mr. William Macklaier

DR. ARMSTRONG: Mr. Chairman, I would like to introduce Dr. Ralph Struthers, who is the Medical Consultant of the Canadian Council for Crippled Children and Adults and Mr. Macklaier, who is a member of my Executive.

THE CHAIRMAN: Do you wish to proceed in whatever way you want to deal with your submission?

DR. ARMSTRONG: I will just read the introduction which forms the summary and the recommendations of the brief.

1. The Canadian Council for Crippled Children and Adults (hereinafter for brevity called The Council) speaks for fourteen provincial organizations which conduct service programs for the rehabilitation of disabled persons. This submission will concern itself

Toronto, Ontario,

--- On commencing at 9.10 a.m.

First submission this morning is from the Canadian Council for Crippled Children and Adults, to be known as Exhibit 31, and Mr. Armstrong will introduce his group to the Commission and present his recommendations.

--- EXHIBIT NO. 310: Submission of the Canadian Council for Crippled Children and Adults.

SUBMISSION OF THE CANADIAN COUNCIL FOR CRIPPLED CHILDREN AND ADULTS

Appearances: Dr. Keith S. Armstrong

MR. ARMSTRONG: Mr. Chairman, I would like to introduce Dr. Jacob Stauthers, who is the Medical Consultant of the Canadian Council for Crippled Children and Adults and Mr. Macklaier, who is a member of my Executive.

THE CHAIRMAN: Do you wish to proceed in whatever way you want to deal with your submission?

MR. ARMSTRONG: I will just read the introduction which forms the summary and the recommendations of the brief.

1. The Canadian Council for Crippled Children and Adults (hereinafter for brevity called "The Council") speaks for fourteen provincial organizations which conduct service programs for the rehabilitation of disabled persons. This submission will concern itself

for the most part with the crippled child.

2. The programs provided by the provincial organizations vary from province to province. Many of the organizations have submitted separate briefs. The range of services provided include early discovery, diagnosis, treatment, parent counselling, public education, prosthetic appliances and equipment, education, vocational training, psycho-social services, recreational summer camps, and transportation. The Council is a federation and as such is concerned with supporting the provincial programs, improving the quantity and quality of services rendered, and studying problems which are of concern to the provincial organizations. A more detailed description of the Council's program is outlined in appendix "D".

3. There are no reliable figures regarding the incidence of crippling among children. Estimates vary between 65,000 and 85,000 children. One difficulty in obtaining an accurate figure is the differences between provinces in their definition of a crippled child. This submission recommends that a register should be established in each province, using uniform definitions and methods of recording.

4. The crippled children's societies provide services to fifty thousand children each year. The nature of these services varies upon the need of the individual child. In some instances it may be necessary only to provide transportation or a special piece of equipment; with others, prolonged medical or educational services may be necessary.

or the least part with the crippled child.

c. The program provided by the provincial organizations vary from province to province. Many of the organizations have submitted separate briefs. The range of services provided include early discovery, diagnosis, treatment, parent counselling, public education, prosthetic appliances and equipment, education, vocational training, psycho-social services, recreational summer camps, and transportation. The Council is a federation and as such is concerned with supporting the provincial programs, improving the quantity and quality of services rendered, and studying problems which are of concern to the provincial organizations. A more detailed description of the Council's program is outlined in appendix "D".

d. There are no reliable figures regarding the incidence of crippling among children. Estimates vary between 60,000 and 95,000 children. One difficulty in obtaining an accurate figure is the differences between provinces in their definition of a crippled child. This submission recommends that a register should be established in each province, using uniform definitions and methods of reporting.

e. The crippled children's societies provide services to fifty thousand children each year. The nature of these services varies upon the need of the individual child. In some instances it may be necessary only to provide transportation or a special piece of equipment; with others, prolonged medical or educational care may be necessary.

5. The combined budgets for the year 1960 of the affiliated organizations was $2,500,000 per annum - of which $1,500,000 is derived from the sale of Easter Seals. In addition to these funds the provincial organizations received $350,000 from government sources in payment for services rendered.

6. This submission is concerned with the contribution of the voluntary agency in the rehabilitation of disabled persons, and in particular the crippled child. The voluntary health agency is not a charitable organization, but rather an association of citizens interested in specific health problems. They are interested in providing community-wide services, measures of prevention, and research. Because of the structure of the health agency, it has a unique and vital role to play in providing total health care for the community.

7. Rehabilitation cannot be considered to be a separate discipline. It can be practised by all professions who recognize four basic principles; namely, (a) the treatment of the individual as a total person, (b) the worth of human personality, (c) the right of every person to the results of existing knowledge which can reduce the effects of disability, (d) the responsibility of the community for the well-being of all its members.

8. The most effective means of achieving this end involves a partnership relation between government services and the voluntary efforts of the people. If, however, the voluntary health

5. The combined budgets for the year 1[illegible] of the eight local organizations was $[illegible] per annum - [illegible] is derived from the sale of Easter Seals. In addition to these funds the provincial organizations received $35[illegible],[illegible]10 from government sources in payment for services rendered.

6. This sum is concerned with the coordination of the voluntary energy in the rehabilitation of disabled persons, and in particular the crippled child. The voluntary health agency is not a charitable organization, but rather an association of citizens interested in specific health problems. They are interested in providing community-wide services, measures of prevention, and research. Because of the structure of the health agency, it has a unique and vital role to play in providing total health care for the community.

7. Rehabilitation cannot be considered to be a separate discipline. It can be practised by all professions who recognize four basic principles; namely, (a) the treatment of the individual as a total person, (b) the worth of human personality, (c) the right of every person to the benefits of existing knowledge which can reduce the effects of disability, (d) the responsibility of the community for the well-being of its members.

8. The most effective means of rehabilitation that end involves a partnership relation between three agencies and the voluntary efforts of the people. It, however, the voluntary health

agencies are to function in such a relationship it is necessary that they co-ordinate their efforts without losing the unique characteristics and strength which they enjoy as specialized agencies.

9. The Council believes that this purpose can be achieved through the proposed Canadian Rehabilitation Council for the Disabled. This is explained in greater detail in paragraphs 53 to 59 of this brief.

10. The recommendations contained in this brief are:

1. That the national voluntary health agencies in co-operation with the appropriate departments of Government, accept responsibility for establishing standard procedures for crippled disabled persons registers so that a summary of the information contained in these registers can be correlated nationally.

2. That with regard to the Disabled Persons Act 1953 - Chapter 35 - The Disability Pension be given without regard to economic means, that it be subject to the Income Tax Act.

3. That a grant-in-aid program for the training of personnel in the social services be initiated by the Government of Canada, and that such grants be in the form of bursaries

Annexure B [1991]

economic use to the extent in such a relationship it is [illegible] [illegible] [illegible]

which will not necessitate the applicant having to have a sponsoring agency to which he is committed following graduation.

Since this brief was submitted, the Department of National Welfare has announced a program which, in part, covers this recommendation.

4. That all National Health and Welfare organizations be required to file with the Secretary of State, an annual financial statement on a prescribed form, which will include:

(a) The gross returns of any national appeal for funds:

(b) The budget allocated to the national office:

(c) The cost of raising these funds:

(d) The amount allocated to public education, advertising, research and services:

(e) Any reserve or designated funds:

(f) Capital funds:

That is the introduction, which is respectfully submitted by the Canadian Council for Crippled Children and Adults.

THE CHAIRMAN: Thank you very much, Dr. Armstrong. Yesterday morning at this time we had the Ontario Society, Dr. Davidson and his associates. Now, they are the Ontario section of this same basic organization?

/resolution 1142

DR. ARMSTRONG: Yes, that is right.

THE CHAIRMAN: And it was my privilege last night, with Dr. Davidson, to go through the rehabilitation centre, the new one on Rumsey Road, and it is a most remarkable institution; that is the one that was just opened.

What part does the Canadian Council play, if any, in the organization and support of such an institution, because I take it there are others throughout Canada?

DR. ARMSTRONG: Our part is more or less a consultative organization. The Canadian Council is a federation of independent, autonomous, provincial societies. We have no direct control over the program that they outline for themselves.

THE CHAIRMAN: Yes, I was thinking more of the financing.

DR. ARMSTRONG: In the financing we are responsible for the production of the Easter Seal, for the type of publicity that is carried on during the campaign, and for any supporting material that we can give the provincial organizations.

THE CHAIRMAN: Still on this matter, that is a public appeal of course, the Easter Seal. Is that the only public appeal which the Canadian Council makes?

DR. ARMSTRONG: Yes.

THE CHAIRMAN: Your Recommendation No. 4, that a return be filed with the Secretary of State. Would you mind expanding that? There must be some

DR. ARMSTRONG: Yes, that is right.

THE CHAIRMAN: And it was my privilege last night, with Dr. Jamieson, to go through the rehabilitation centre, the new one on Turner Road, and it is a most remarkable institution; that is the one that was just opened.

What part does the Canadian Council play, if any, in the organization and support of such an institution, because I have it there are others throughout Canada?

DR. ARMSTRONG: Our part is more or less a consultative organization. The Canadian Council is a federation of independent, autonomous, provincial societies. We have no direct control over the programs that they carry out, nor for themselves.

THE CHAIRMAN: Yes, I was thinking more of the financing.

DR. ARMSTRONG: In the time ahead we are responsible for the promotion of the Easter Seal, for the type of promotion that is carried on during the campaign, and for any supervision, rather, that we can give the provincial organizations.

THE CHAIRMAN: Still on this matter, that is a public appeal of course, the Easter Seal. Is that the only public appeal which the Canadian Council makes?

[illegible]: Yes. Would you recommend to [illegible], that a petition be filed with the Secretary of State, could you mind explaining that? There must be some

discussion, some reason why this type of recommendation would come forward at this time?

DR. ARMSTRONG: The reason Recommendation No. 4 was placed in there is the fact that we believe that the citizen wants to support the charity of his choice. That he has an interest in some activity in his community, and that the basis of a good deal of criticism that is levied against the voluntary agency is the uncertainty in the mind of the donor as to whether or not his money is really going to the cause for which he gave it.

We don't believe that government can control the activity of the voluntary agency, but in one regard the Government, we feel, has a responsibility, and that is to safeguard money that is being given by the citizen to some particular cause.

Now, you can get the financial report of any organization that you ask for but it is difficult to compare those financial statements, because auditors make them up differently. They are made up for different purposes, and so forth, and we feel that if there was a uniform format that agencies had to follow, they could be compared and could be filed with the Secretary of State, so that its use wouldn't be abused. That this would give the confidence that the donor wants to contribute to whatever he happens to be interested in.

THE CHAIRMAN: Perhaps, Mr. Macklaier, this question may be more properly addressed to you. Do you see, in our constitutional position, the feasibility of Parliament making such a stipulation?

discussion, some [illegible] this type of [illegible]
[illegible] come forward [illegible]

tion [illegible], it was a good [illegible] the [illegible] that we
believe that the [illegible] were to support the charity
of his choice. That he has [illegible] in some activity
in his community, and that [illegible] of a good deal of
[illegible] that [illegible] agency
in the uncertainty in the mind of the donor as to
whether or not his money is really going to the cause
for which he gave it.

[illegible] to leave that uncertainty
and control the reality of the voluntary support, but
in the round-up [illegible], we [illegible], for a responsibi-
lity, and that is to account for money that is being
given by the citizens to some particular cause.

[illegible], we can get the financial report
of any organization [illegible] for but it is difficult
[illegible]

[illegible] time to [illegible] [illegible] made up for different
purposes, and so forth, and we felt that it [illegible] was
a [illegible] that [illegible] had to fall, the
[illegible] could be filed with the Secretary
of State, so that the [illegible] can't be abused. That
[illegible] would give the [illegible] that the donor [illegible] to
[illegible] to [illegible] to be [illegible].

[illegible] Chairman, Mr. [illegible],
this question may perhaps [illegible] address to you
[illegible] you see, in [illegible] tuitional position, the [illegible]
[illegible] of [illegible] [illegible] such a [illegible]?

MR. MACKLAIER: Well, Mr. Chairman, that does raise a nice constitutional question, of course. I suppose there is some precedent for it in the Act which has received Royal assent, but has not been proclaimed in force. It is this fancy Act, with the fancy titles, which includes labour unions, but I think that includes all organizations within the federal jurisdiction of the federal authority.

Now, whether or not there is some broad aspect of, say, Section 91 of the B.N.A. Act that of itself would be sufficient sanction for this, I would hope there might be, but this is something which is at national health level and in the interests of national health we ask that this be done.

Whether any teeth could be put in such a thing to put the bite on provincial organizations, we chose not to do it. Let us say that would be a nice question.

THE CHAIRMAN: I suppose you are starting over from scratch, and when the organization goes to Parliament for their special Act or private bill or even to the Secretary of State for incorporation, that the condition might be written in to require a report in a certain form?

MR. MACKLAIER: Yes, of course. I think if one proceeds on the premise that the organization is a gift of the federal authority, in those cases I don't think you would need it in the charter. You could put it in the general Act, just as in this new federal Act, which has, as I say, been assented to, but

[illegible] MACDONALD: Well, Mr. Chairman, it does [illegible] restrictive provision, of course. I [illegible] the President from [illegible] not merely [illegible] real assent, but has not [illegible] proclamation [illegible] Fair Wage Act, with the Fair Wage [illegible], which [illegible] labour unions, but I think that the [illegible] provinces within the federal jurisdiction [illegible] authority.

[illegible] broad aspect of [illegible] of the N.R.A. Act that of itself would be sufficient reaction for me. I would hope there might be, but this is something which is at national labour level and in the interests of national peace we ask that it be done.

[illegible] any teeth could be put in such a clause to [illegible] provincial compulsion, we close not [illegible] that we say that would be a nice

[illegible] I suppose you are [illegible] over the [illegible], and when the organization goes to Ottawa for their special act or private bill or even to the [illegible] or state for incorporation, that [illegible] is [illegible] to [illegible] a [illegible] in a [illegible].

[illegible] think it [illegible] on the [illegible] that the [illegible] tion is a matter of the internal autonomy, in those cases I [illegible] [illegible] could not be in [illegible] Act, just as in this [illegible] [illegible] been [illegible], but

not put in force. That applies to all organizations which come under the federal authority. You didn't have to put it in their charters to say that you shall do such-and-such a thing.

3L/ss

THE CHAIRMAN: No, but I was thinking even in those case where incorporation may be obtained in Ottawa under what is now the Provincial field, but some addition may be written into the private bill.

MR. MACKLAIER: Right.

THE CHAIRMAN: Such as we have had under, not quite comparable, but under the religious societies.

MR. MACKLAIER: Right. One question, Mr. Chairman, you asked Dr. Armstrong, an illustration as to just what is the character of the Canadian Council.

I have always felt that the very simplest explanation of that is that it is somewhat like the Association of Canadian Clubs, of which most of us know, its relationship to the Canadian Club in Montreal, the Canadian Club in Winnipeg, and so forth. It is there to assist each of the local organizations, although the local organizations are not organically a part of the Federal organizaton.

In your reference to the Ontario Society yesterday, you said it was part of our organization. Well, it is and it isn't; it is not organically part of our organization. Our organization is the Federal organization which endeavours to correlate all these organizations and service as a common meeting place of each and common pool of each, trying to impart that to all of the others, and that is duly developed in the paragraph on organization.

I just want to make it quite clear that the Canadian Council is above all these others.

... [illegible]. Yes, but I was thinking

even in those cases where incorporation may be obtained

in Ottawa during that - i.e. the Provincial field, but

some additional new - matter into the private bill.

Mr. [illegible]. Right.

Mr. [illegible] - Such as we have had

under, not under corporations, but under the religious

societies.

Mr. Chairman, you asked Mr. Armstrong, an illustration

as to just what is the character of the Canadian Council.

I gave above just that the very

slightest explanation of that is that it is somewhat like

the Association of Canadian Clubs, of which most of us

know, the relationship to the Canadian Club in Montreal,

the Canadian Club in Winnipeg, and so forth. It is

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organization which endeavours to correlate all these

organizations and service as a common meeting place of

each and common pool of ideas, trying to create that to

all of the others, and that is only developed in the

paragraph on organization.

I just want to make it quite clear

that the Canadian Council is above all those clubs.

They are affiliated to it, but they are not organically part of it.

And similarly fund-raising. The annual Easter Seal campaign is put on in virtue of a franchise which emanates from the Canadian Council, but it is actually put on at Provincial level by Provincial organizations. So it is rather a hybrid thing. All the money from the Easter Seals does not all roll into the coffers of the organization; they get a very modest percentage of it, for the Canadian Council as such to keep functioning.

COMMISSIONER VAN WART: After Section 53-59, when you speak of the present organizations being amalgamated and no longer exist as such, what is the relationship to the Provincials? Do the Provincials have a similar merger or do they still have a close, or dissociated with the parent body?

MR. MACKLAIER: From the legal point of view the expanded, let's call it Federal organization will be somewhat in pattern to the other organization, but they will have got bigger and become big by process of amalgamation. The Provincial organizations which will work in affiliation with the expanded Federal organization will be autonomous, just as they are autonomous now.

MR. ARMSTRONG: In seven out of the ten provinces this Provincial merger is already taking place, and the purpose is to complete that on the national level and also to provide a medium for the other organizations interested in rehabilitation who can become associated with this and find a meeting-ground for all

the associations interested in this field.

MR. MACKLAIER: It is a very wonderful and exciting thing.

THE CHAIRMAN: I know it is in operation in the Province of Saskatchewan.

DR. ARMSTRONG: Yes. The Province of Saskatchewan and its Council. It is a sort of a pattern of what we hope will be seen on the national level.

COMMISSIONER VAN WART: There is no change, then, in the relationships between the Provincial and the Federal; it is that same loose thing, it is not brought closer together or spread further apart.

DR. ARMSTRONG: We think this would help very definitely to it being a Federal responsibility.

THE CHAIRMAN: I want to go back to this point of which Item 4 is a manifestation. Have you any view to give on this what we might call multiplicity of appeals by national and Provincial organizations for the charitable dollar? This is in terms dealing with that subject but in a more limited way. Yesterday the Canadian Organization of Health and Physical Education, and so forth, were suggesting there should be a coordinating body in Canada to control and, perhaps not legal control, but to exercise some form of cooperative control over all these appeals, and that would be including yours as well.

Have you any views to express on that, the multiplicity of appeals, and whether anything can be done to prevent the further fragmentation of the field and the increasing number of appeals?

the associations interested in this field.

Mr. McCRACKEN: It is a very wonderful and exciting thing.

Mr. CHAIRMAN: I know it is in operation in the province of Saskatchewan.

Mr. ABBOTT: Yes. The province of Saskatchewan and its Government. It is a sort of a pattern of what we have been in the national level.

Mr. CHAIRMAN: Will we?: There is no change, then, in the relationship between the provincial and the federal; it is just more loose than. It is not brought closer together or brought further apart.

Mr. McCRACKEN: We think this would help very definitely to bring a federal responsibility.

Mr. WALKER: I want to go back to this point of which I am. It is a manifestation. Have you any view to give on this what we might call multiplicity of appeals by national and provincial organizations for the charitable dollar. This is in terms dealing with that subject but in a more limited way. Yesterday the Canadian Foundation of Health and Physical Education, and so forth, were in meeting there should be a coordinating body in Canada to control and, perhaps not legal control, but to exercise some form of cooperative control over all these agencies, and that would be involving your [illegible]

Have you any ideas to comment on that, the multiplicity of appeals, and whether anything can be done to [illegible] further the operation of the field and the increasing number of appeals?

DR. ARMSTRONG: We feel that this new organization should facilitate this problem. As an illustration, the Canadian Cysticfibrosis Foundation was organized in 1959 and was organized by a group of parents who were very much concerned with the very real problem, which included drugs, inhalation equipment, and so on, and they had encouragement from the National Foundation in the United States to go out on a fund-raising appeal, and so on, and they came to us for advice and we took the attitude that these people had a legitimate concern and a legitimate right to become organized to try and meet their problem. If we can find the answer to their problem within the existing resources of the voluntary agencies and Governments themselves, we had no right to prevent them going to the public.

So what we have done is provide them with the necessary administrative facilities in the office, we give them service.

And we have also opposed the various agencies who have related interest to their problem, but we are hoping we can find a solution for their problem without the necessity of their going to the public on another appeal. This group has been very happy to join in that type of relationship, and I feel that if the major voluntary health agencies in Canada will accept this type of responsibility to these new problems as they come up the multiplicity of appeals can be controlled, but if you try to force control, then the health agencies immediately get on the defensive.

THE CHAIRMAN: Can you foresee some form off a cooperative effort on the part of these major

DR. ARMSTRONG: We feel that this new organization should facilitate this problem. As an illustration, the Canadian Cystic Fibrosis Foundation was organized in 1949 and was organized by a group of parents who were very much concerned with the very real problem, which included drugs, inhalation equipment, and so on, and they [illegible] encouragement from the National Foundation in the United States to go out on a fund-raising spread, and so on, and they came to us for advice and we took the attitude that these people had a legitimate concern and a legitimate right to become organized to try and meet their problem. If we can find the answer to their problem within the existing resources of the voluntary agencies and Governments themselves, we had no right to prevent them going to the public.

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MR. CHAIRMAN: Can you foresee some form of a cooperative effort on the part of these major

and minor appeals to deal with the problem as you did deal with cysticfibrosis?

DR. ARMSTRONG: Whether it is utopian or not, we would hope this would develop.

THE CHAIRMAN: We are seeing that the appeals for funds are beginning to experience difficulties, and one of the answers is the multiplicity, and some communities have tried to solve it by united appeals, and so forth, and now we are getting to the point where there are quite a few still outside the community appeal; the growth is unending in that respect.

MR. MACKLAIER: Mr. Chairman, speaking defensively -- although I don't think you have put us on the defendsive ---

THE CHAIRMAN: No.

MR. MACKLAIER: It is interesting, if and when it materializes, I think their course in this respect is a very good example, because they got the organizations affiliated when they would only have the two appeals, one Easter Seals, which is now characteristic of the organizations affiliated with the Canadian Council, and the other the March of Dimes, which is affiliated with the Polio Foundation. I don't like this grass roots expression, but they are grass roots appeals, $2.00, $5.00, $10.00; $10.00 is big money on these appeals and nobody minds, it doesn't call for a huge campaign organization, it doesn't call for pace-setting gifts from the chartered banks.

So this organization as it now exists or proposes to be, you have got something which is pretty

and minor appeals to deal with the problem as you did deal with earlier ones?

MR. ARMSTRONG: Whether it is utopian or not, we would hope this would develop.

MR. CHAIRMAN: We are seeing that the appeals or forms are being -- to experience difficulties; are one of the areas, i.e. the multiplicity, and some communities have tried to solve it by united appeals, and so forth, and now we are getting to the point where there are quite a few still outside the community appeal; the problem is unending in that respect.

MR. MACDONALD: Mr. Chairman, reaching defensively -- although I don't think you have put us on the defensive ---

MR. CHAIRMAN: No.

MR. MACDONALD: It is interesting, if and when it streamlines, I think their course in this report is a very good example, because they got the organizations affiliated when they would only have the two appeals, one Easter Seals, which is now characteristic of the organizations affiliated with the Canadian Council, and the other the March of Dimes, which is affiliated with the Polio Foundation. I don't like this cross route or operation, but they are cross route appeals, 72 Ot, 5 Can, 7 Ph 2C. Ulu.Of is big money on these appeals and money alone, it doesn't call for a have community organization, it doesn't call to pace-setting, it is from the traditional basis.

In the organization as it now exists or purposes to be, you have got something which is really

close to ideal. Of course, as the members of your Commission from my province know, there is no place where the situation of which you speak is worse than in Montreal. We have just so many appeals that if you wanted to take some place as your experimental place, take Montreal, and we hope by next year there willbe a second United Appeal when all the health agencies will have got together and will put on a unified appeal with the Red Feather Appeal. I don't think your Commission can do anything about that, but part of the situation was that they said you have got to do something like this. We are going to stop giving you these people. Until "big business" took the attitude you would never succeed in joining it. I think that is the position that you have to take, that the banks say that you have got to do something like that.

THE CHAIRMAN: We were discussing it with an organization such as yours, because there is no implication at all except in the general discussion. It is germane in a measure to the inquiry, because if we move forward in any form of national or Provincial health service, this question of appeals by the health agencies would become quite important.

DR. STRUTHERS: May I speak in reply to your direct question, sir?

THE CHAIRMAN: Yes.

DR. STRUTHERS: I think this question you referred to yesterday is probably an expression of public impatience. I think the first suggestion there should be some type of Government supervision.

close to home. Of course, as the members of your Commission know, at present there is no place where the situation of which you speak is worse than in Montreal. As Mr. Prat so truly appeals that if you wanted to take some place as your experimental place, take Montreal, and we hope by next year there will be a second United Fund when all the health agencies will have got together and will put on a united appeal with the Red Feather Appeal. I don't think your Commission can do anything about that, but part of the situation was that they said you have got to do something like this. We are going to stop giving you these people until "this business" took the attitude you would never succeed in totaling it. I think that is the position that you have to take, that the banks say that you have got to do something like that.

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MR. STRUTHERS: May I speak in reply to your direct question, sir?

THE CHAIRMAN: Yes.

MR. STRUTHERS: I think this question was referred to yesterday is probably an expression of public interference. I think the first suggestion there should be some type of Government supervision.

There was an ad hoc committee in the United States which arose from a campaign, and there was a great sum of money raised of which quite a sum wasn't returned, and the suggestion by this ad hoc committee was that there should be some Government supervision, because these were tax monies.

COMMISSIONER FIRESTONE: There was also mention about health voluntary organizations, three members going out on a voluntary campaign. I don't know if any instances of that have come to your attention.

DR. STRUTHERS: I have only the information about that ad hoc committee of which I spoke.

DR. ARMSTRONG: I think we have more control of that type of thing than in the United States. There was a person who put an ad in the New York Times and they took in $10,000.00; the people just gave without knowing what they were giving for. I doubt if that could happen in Canada, because we have sufficient public opinion to provide against that type of thing.

COMMISSIONER FIRESTONE: If you had an organization consisting of three members going out collecting funds, they may be raising funds which may not finally end up for the purpose for which they were collected, and there must be some sort of a problem arising out of this sort of arrangement, and my question is: Are there such instances in Canada, do you know about them?

DR. ARMSTRONG: No.

COMMISSIONER FIRESTONE: It was suggested to us there are.

MR. MACKLAIER: In answer to Mr.

Firestone, surely the amount of money that an effort like that is seeking to raise is important money, that is the kind of money that the donor would want to get a receipt for so he could use it for tax purposes. Surely the organization of the Income Tax Division is or should be such that it can control that, because, after all, in order to give a valid receipt you must be an accredited charitable organization under the The Income Tax Act, and that is pretty well defined in The Act, and I think it is pretty well policed. The people who give nickels, dimes and dollars, two dollars, you don't want a receipt. In regard to putting the ad in the New York paper, surely that is one way of controlling it at the Federal level.

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The other way is for perhaps this Commission to commend the attitude of big business and say "You are perfectly right in taking this attitude and stick to it", because you may be the main source for putting across this philosophy that these organizations must get together.

THE CHAIRMAN: To get to another subject, your second recommendation, would you mind explaining that?

DR. ARMSTRONG: In the present Disabled Persons Act the pension is given to a severely disabled person who is not employable. Now, he is allowed a certain minimum outside income and there are many instances where, through a homebound program these persons are able earn a certain amount of money and gradually increase this earning until eventually they might become self-supporting. Once they reach their outside income they hesitate to jeopardize the security of their pension.

THE CHAIRMAN: Is that a complete loss or a gradual build-up?

DR. ARMSTRONG: It differs in various provinces but usually even though it is a gradual loss there is a lag in catching up on the outside income so that the person may find themselves without any income at all for a month while this extra that has been earned has been recovered.

THE CHAIRMAN: You are going to put this on the same basis as the Old Age Pension?

DR. ARMSTRONG: Yes. If a severely

The answer is for us to use this
omission to remember the attitude of Lincoln and
say "Yes we are perfectly right in taking this attitude
and also to 'all', because we may be the main source
of mutiny across this philosophy that these one-sides
tions must not take place.

Q. Question. Is not to an that
end act, your second recommendation, would you mind

Mr. ARNOTT(NSW): In the present
instance because not the question is given to a severely
diseased person who is not employable. Now, he is
allowed a certain minimum outside income and there are
many instances where, through a nonexhausted pension these
persons are also given a certain amount of money and
consequently increase the question until eventually they
might become self-supporting. Once they reach their
outside income they are able to supplement the
security of their pension.

Mr. CHAIRMAN. Is that a complete
loss on a pensioned individual?

Mr. ARNOTT: It differs in various
circumstances but usually when there is a pensioned
line there is a loss in coming up on the outside
income so that the person may find themselves without
any income at all for a month while there was that
has been actually has been lessened.

Mr. CHAIRMAN: You are asking to put
this or the case based on the old age pensioner.

Mr. ARNOTT: Yes. It is exactly

disabled person did become employable this disability pension would form a means of giving him extra support to get transportation to work and all the extra costs he is involved in because of a disability in working.

THE CHAIRMAN: And if he finally gets to the point where he has an excess the income tax will take it away from him.

DR. ARMSTRONG: Yes.

DR. STRUTHERS: May I expand on recommendation number one?

THE CHAIRMAN: You are perfectly free to make any observations you wish on this matter.

DR. STRUTHERS: This has to do with the setting up of registries of crippled children and adults and it is important from two points of view. The first one would be that we have at present no accurate knowledge of the total problem of the disabled child in Canada as regards number or disability. From a service point of view this would be a valuable thing to know. The second thing, and to my mind more important, is from the point of view of research and medicine. We are being struck more and more with the frequency of disabilities stemming from congenital abnormalities of unknown origin and the people working in genetics are interested in such a registration so they can follow through family trees to see the progress of the disability in the various channels. This has been worked on very ardently under the Atomic Energy Company of Canada at Chalk River on the inherited or genetic difficulties. We do need a registry of crippled children

disabled person and leaves employable this disability pension would form a means of giving him extra support to get transportation to work and all the extra costs he is involved in because of a disability in working.

THE CHAIRMAN: And if he finally gets to the point where he has an excess the income tax will take it away from him.

Mr. STRUTHERS: May I expand on

THE CHAIRMAN: You are perfectly free to make any observations you wish on this matter.

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showing the type of abnormality which is present which would help us with the research problem and give us a definition of the total problem in Canada.

THE CHAIRMAN: What would you say is the appropriate department in respect to responsibility? Have you something more specific?

DR. STRUTHERS: The appropriate department of government under the health and welfare division and a child registry should be set up under provincial organization but the idea of having a collecting group would be to collate the whole thing for statistical study.

THE CHAIRMAN: We were discussing this registry with the Ontario Association yesterday morning and that was what they thought. They were not able to give us the number for Ontario, even.

DR. STRUTHERS: An educated guess, that is all.

THE CHAIRMAN: They were able to do a little better on the Metropolitan Toronto area.

DR. STRUTHERS: The work to be done will have to cover the province so they can have a standard form of registry and nomenclature. At the present time there are three types of nomenclature in use, the international is being used in British Columbia which is the W.H.O. one; in one other province they are using a standard with is the United States nomenclature set-up and in two other provinces various elaborations of either or both which they have worked out within the means they have at their command.

showing the type of uncertainty which is present which would help us with the research problem and give us a definition of the rural problem in Canada.

MR. CHAIRMAN: What would you say is the appropriate department in respect to responsibility? Have you something more specific?

DR. STANLEY: The appropriate department of government under the Bureau of Welfare division and a child security should be set up under provincial organization but the idea of having a collecting group would be to isolate the whole thing for statistical study.

THE CHAIRMAN: We were discussing this registry with the Ontario Association yesterday morning and that was what they thought. They were not able to give us the number for Ontario, even.

DR. STANLEY: An educated guess, that is all.

THE CHAIRMAN: They were able to do a little better on the Metropolitan Toronto area.

DR. STANLEY: The work to be done will have to cover the province so they can have a standard form of registry and numerical score. At the present time there are three types of numerals are in use, the Lorenzo one is being used in British Columbia which is the only, or one of one other province they are using a standard which is the United States numerical type using an in the corner, so that a person can usually be located no matter which they have moved to within the years they have at their command.

COMMISSIONER STRACHAN: What are the number of variations in the definition of crippled children?

DR. ARMSTRONG: This runs all the way from a narrow orthopaedic definition which is the classic one to cover mental health, retardation and it is just as broad as you want to make it. The definition that the Canadian Council use a very broad definition except we modify it by saying where there is an association to give care for a specific group that we do not include that group in our definition. This is in a sense a pragmatic thing.

COMMISSIONER STRACHAN: Is the Ontario definition broader than the average? It was outlined in their brief yesterday.

DR. ARMSTRONG: It would be broader than most. The narrowest definition is in Nova Scotia and New Brunswick and the broadest is in Saskatchewan and Alberta.

COMMISSIONER STRACHAN: Even broader than Ontario?

DR. ARMSTRONG: Yes, I think in Saskatchewan crippled children is any child that can benefit from the service we offer.

THE CHAIRMAN: It begs the question.

DR. ARMSTRONG: We say a crippled child may be defined as a handicapped person who suffers from any disability severe enough to interfere with his getting an education or earning of a livelihood which is pretty broad.

CONSTABLE STRACHAN: What are the number of variations in the definition of criminal conduct?

DR. MACDONALD: This runs all the way from a narrow category to definition which is the clearer one to cover man's health, restoration and it is just as broad as you want to make it. The definition that the Canadian Council has a very broad definition except we really in by saying where there is an association to give care for a social group that we do not include that group in our definition. This is in a sense a pragmatic thing.

CONSTABLE STRACHAN: Is the dynamic criminal process from the average? It was outlined in their brief yesterday.

DR. MACDONALD: It would be broader than most. The narrower definition is in Nova Scotia and New Brunswick and the broadest is in Saskatchewan and Alberta.

CONSTABLE STRACHAN: Does broader mean criminal?

DR. MACDONALD: Yes, I think in Saskatchewan crippled children is any child that can run it from the service we offer.

DR. DA SILVA: It begs the question.

DR. MACDONALD: We say a crippled child may be defined as a handicapped person who suffers from any disability severe enough to interfere with his getting an student or earning of a livelihood which is pretty broad.

COMMISSIONER STRACHAN: But you do not point out specifically?

DR. ARMSTRONG: The muscular skeleton, no, because we feel we have the organization and also the experience to help small specific interested groups and we should be able to keep them in our definition if they want to come.

COMMISSIONER FIRESTONE: Dr. Armstrong, on this point of establishing registries of the crippled children on a provincial basis, a national summary of all the information available on a provincial basis, have you in mind perhaps a little bit more than just statistical collection?

DR. ARMSTRONG: Yes.

COMMISSIONER FIRESTONE: Uniformity of definition and methods of obtaining that information. Do you have in mind to do a certain amount of analysis and then perhaps develop some conclusions and recommendations?

DR. ARMSTRONG: That is right. The British Columbia registry for crippled children has been about the only effective registry that I have seen either in Canada or the United States. This has been excellent. I think their purposes are very sound. The first is early discovery of cases; the second is that they refer these cases then to the services which can be of assistance to them. Now, this is done and it protects the doctor-parent relationship, there is no violation of that. The third is a follow-up. The fourth function is as an analysis of need. Somebody in British Columbia

MR. [illegible] R. STARNAM: Sir, may I do not point out [illegible]?

[illegible]

No, because we feel we have the organization and also the expertise to help even specific interested groups and we should be able to keep them in our definition if they want to come.

[illegible]

On this point of establishing priorities of the original children on a provincial basis, a national summary of all the information available on a provincial basis, have you in mind perhaps a little bit more than just [illegible]

[illegible]

No, [illegible] yes.

[illegible]

of definition and methods of obtaining that information. Do you have in mind to do a certain amount of analysis and then perhaps develop some conclusions and recommendations?

DR. [illegible]: That is right. The British Columbia ministry for original children has been about the only effective ministry that I have seen either in Canada or the United States. This has been excellent. I think their projects are very sound. The first is early dia [illegible] of course; the second is that they refer these cases then to the [illegible] which can [illegible] assistance to them. [illegible], this is done and in protecting the doctor-[illegible] relationship, there is no violation of that. The third is a follow-up. The fourth function is as an analysis of [illegible]. [illegible] in [illegible], [illegible]

proposed a clinic on epilepsy and they used the registry to analyze the extent of need in the field of epilepsy. Finally there is the means of research and the proper advisory board which examines the figures. Now, if the type of registration with certain modifications were adapted across Canada it would be of very essential value, it would be a nation-wide correlation of these figures.

COMMISSIONER FIRESTONE: I take it from your recommendation in paragraph 10, subparagraph 1 it relates to the appropriate governing agency of the federal department then to not only collect such statistics, to undertake such analysis and bring out some of the conclusions that the evidence would suggest for whatever use the government or voluntary agencies consider it desirable?

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essential value. It could be a nation-wide correlation
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CONGRESSMAN FINDLEY: I ask
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federal department then to not only collect such
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for whatever use the government or voluntary agencies
consider it desirable.

B/dpw

We have discussed this with the people in the Federal Government and they feel that the spadework and the development should be within the scope of an agency such as ours working closely with them and when the project has been developed the actual operation of the natural fluoridation, of course, would be naturally a government function. I think that is an illustration of where you can get this partnership between government and the voluntary agency.

COMMISSIONER FIRESTONE: Do I take it from what you are saying, sir, that you will not be content with the Department of Health and Welfare or the Bureau of Statistics just using some tables, but you would feel once the tables are produced certain other work should follow?

DR. ARMSTRONG: That is right; the statistics in themselves won't do a thing unless they are related to the needed services.

COMMISSIONER FIRESTONE: Thank you, sir. That is what you have in mind in this recommendation in paragraph 10, sub-paragraph 1?

DR. ARMSTRONG: Yes.

COMMISSIONER FIRESTONE: Thank you very much. Now, may I turn to your next recommendation in this main paragraph 10 and that is something that has already been referred to with regard to the Disabled Persons Act, 1953, which you have suggested should be amended. If your recommendation was adopted and perhaps I should address this question to Mr. Macklaier; if this

We have discussed this with the people in the federal government and they feel that the framework and the development should be within the scope of an agency such as ours working closely with them and when the project has been developed the actual operation of the national fluoridation, of course, would be naturally a government function. I think that is a distribution of where you can get this partnership between government and the voluntary

COMMISSIONER FOR HEALTH: Do I take it from what you are saying, sir, that you will not be concerned with the department of health and welfare or the bureau of statistics just using some tables, but you would feel once the tables are produced certain

DR. ATKINSON: That is right; the statistics in themselves won't do a thing unless they are related to the needed services.

COMMISSIONER FITZGERALD: Thank you, sir. That is what you have in mind in this recommendation in para. 10, sub-paragraph 2?

DR. ATKINSON: Yes.

CHAIRMAN, DIRECTOR: Thank you very much. Now, may I turn to your next recommendation in this main paragraph 10 and that is something that has already been referred to with regard to the Disabled Persons Act, 1953, which you have suggested should be amended. If your recommendation was adopted and perhaps I would address this question to Mr. Lakeland, is this

recommendation was adopted you would be changing the principle, the principle being to support the needy, support the people with certain handicaps, irrespective of need. Now, where the recommendation as has been presented to us perhaps financial need still exists because of other expenses involved which you have expanded. I am just wondering whether the Government that would have to consider such a recommendation wouldn't feel there is an important change of principle beyond the legislation or beyond the statute as it exists at the moment.

MR. MACKLAIER: Mr. Commissioner, that might be so, but, of course, there would be ample precedent as Dr. Armstrong mentioned in his statement, it is the old-age pension formula. It is the principle of that applied to a different field, isn't it? I know I get into many arguments at home with my wife who takes a very dim view of people such as our plutocrats drawing old-age pensions. She says, "What utter nonsense Mr. So-and-So gets it." I say he pays it back in income tax and it is much simpler to do it in that way from the Government's point of view than to impose a means test.

In the case of the disabled person, if he is fortunate enough to make something in a sheltered workshop, nevertheless he starts out under a tremendous handicap which he will probably never overcome, therefore, this, in a sense, would be a very modest bonus to him because of the fact that he is saddled with this handicap and will never, probably, succeed in

[illegible] reason for we adopted you would be changing the principle, the policy, to seize to support the needy, support the people with certain benefits, irrespective of need. Now, where the recommendation as has been presented to us perhaps there's a need that exists because of other changes that have been expanded. I am just wondering whether the Government that would have to consider such a recommendation wouldn't feel there is an important change of principle beyond the legislation or beyond the statute as it exists at the moment.

MR. MACKLAUGHLIN: Mr. Commissioner, that might be so, but, of course, there would be ample precedent as the attorney mentioned in his statement, it is the old-age pension formula. It is the principle that applied to a different field, isn't it? I know I get into many arguments at home with my wife who takes a very dim view of people such as our piecemeal drawing old-age pensions. She says, "What utter nonsense. Go-and-do pots it." I say he pays it back in income tax and it is much easier to do it in that way from the Government's point of view than to impose a means test.

In the case of the disabled person, it is a tolerable burden to make something in a disabled worker so. Nevertheless he starts out under a certain disadvantage which he will probably never overcome throughout life, in a sense, would be a very dolorous thing to the legislature or the last court to undertake with the mentioned and will, however, probably be used in

overcoming his handicap. The fact that he may be able to make a few dollars and that these dollars may become more than a few doesn't change the fact that he is still disabled and probably doing it under great stress and under great difficulty. I think that is a valid point.

COMMISSIONER FIRESTONE: I am just wondering if, as an alternative approach to it, the same objective you outlined to us, sir, could not be achieved by raising the level of the maximum allowable outside income that could be earned; the point which you discuss in paragraph 43, and the last sentence of that paragraph.

MR. MACKLAIER: Mr. Chairman, in the preliminary drafting of the brief, that was the recommendation we were thinking of submitting. In discussing it with the Canadian Paraplegic Association they persuaded us to change our mind to this particular recommendation because of the fact even though a severely disabled person is working he is faced with unusual expenses.

A girl who works in my office, who drives her own car to work - she is a paraplegic and has to work with hand gears and has to get help upstairs - she cannot take the streetcar. She has to have a car and that type of thing, which the pensioner has the right, would enable the severely handicapped person to compete without quarter with the able-bodied person on the job.

COMMISSIONER FIRESTONE: I may say, Dr.

overcoming his handicap. The fact that he may be able to make a few dollars and that these dollars may become more than a few doesn't change the fact that he is still disabled and probably doing it under great stress and under great difficulty. I think that [illegible] point.

I am just considering it, as an alternative approach to it, the sort of motive you outlined to us, sir, could not be achieved by raising the level of the maximum allowable outside income that could be earned: the point which you discuss in paragraph 6a, and the last sentence of that paragraph.

[illegible]

Realistically speaking or the broad, that was the recommendation we were thinking of submitting. In discussing it with the Canadian Paraplegic Association they persuaded us to change our mind to this particular recommendation because of the fact even a quite severely disabled person is working to be faced with unusual expenses.

A person who works in a wheelchair, who drives her own car to work - she is a paraplegic and who to work into from across and has to get her wheelchair out of another car in [illegible]. She has to have a car and that type of thing, which the paraplegic has the right, just as much as the severely [illegible] person to compete with [illegible] the [illegible] and [illegible] on the job.

I mean, Dr.

Armstrong, you make a very convincing case for it. These are your recommendations and we accept them in the spirit they have been put to us.

May I now turn to another point that has already been discussed, and that is your Recommendation 4 in main paragraph 10. I take it the objective behind this recommendation is that you wish to make sure that all this information is made public; it is not only the fact that the return is presented to the Secretary of State each year, but the information be made public so the public knows what is going on?

DR. ARMSTRONG: Yes.

COMMISSIONER FIRESTONE: Do you have in mind these agencies in addition to submitting this information on the prescribed form may also make information public in a statement or report which they may turn out once a year?

DR. ARMSTRONG: We feel this would follow. The Canadian Council for Crippled Children, for instance, had to fill out a prescribed form to the Secretary of State. The Canadian Council then would have to get the affiliated organizations, selling Easter Seals, that information also would be on that prescribed form and once this had been completed the Canadian Council, by its policy or by its constitution, has this information available to anybody who would wish to see it so that the individual wouldn't have to go to the Secretary of State for it. He could come direct to the agency.

COMMISSIONER FIRESTONE: You see, you

Chairman, we have a very distinguished panel here. These are your representatives and we accept them. The witnesses have been sworn to us.

May I now turn to another point that has already been discussed, and that is your recommendation in main document 1A. I take it the objective behind this recommendation is that you wish to make sure that all the information is made public; it is not only the fact that the report is presented to the Secretary of State each year, but the information be made public so the public knows what is going on?

A. ANSWERING: Yes.

CHAIRMAN PRESTON: Do you have in mind these agents as in addition to submitting this information on the prescribed form may also make information public in a statement or report which they may turn out once a year?

A. ANSWERING: We feel this would follow. The Canadian Council for Crippled Children, for instance, had to fill out a prescribed form to the Secretary of State. The Canadian Council then would have to get the provincial organizations, saying their basis, that information also would be that prescribed form and once this had been done the Canadian Council, in the spirit of the constitution, was this information available to anybody who wanted to see it so that the individual would have to go to the Secretary of State's for it. We could comment to the answer.

CHAIRMAN PRESTON: You see, you

speak of your own group, but your recommendation, if I understand it correctly, applies to all national health and welfare organizations.

DR. ARMSTRONG: Yes.

COMMISSIONER FIRESTONE: And presumably you would expect other organizations to behave as rationally as you are planning to behave yourself?

DR. ARMSTRONG: We feel this responsibility is government's, to see we do behave rationally.

COMMISSIONER FIRESTONE: How would the Government achieve that?

DR. ARMSTRONG: Part of the terms of the Charter that we received from the Federal Government states that we make a return once a year to the Secretary of State with certain information under the Companies Act and it wouldn't be too much of an innovation to prepare a special form for the voluntary agencies rather than adopting the form that the companies use in making their returns.

MR. MACKLAIER: After all, Mr. Chairman, if you are incorporated as a charitable, as a non-profit, organization you cannot even change your by-laws without prior sanction of the Department of the Secretary of State, so if one starts from that one shouldn't mind, it seems to me, being asked to file statistical information of this character.

COMMISSIONER FIRESTONE: Let us assume that this recommendation were adopted and implemented. It would still only provide Canada with information as to the operations of national health and welfare

[illegible] work of your [illegible], but your report [illegible], is [illegible] unnecessarily, [illegible] to [illegible] health and welfare organizations.

[illegible] MITCHELL: And [illegible], you would [illegible] when [illegible] to behave as that [illegible] we are planning to behave [illegible]?

[illegible]: In addition, do feel this [illegible] is [illegible], to see we do behave nationally.

The government believe that

[illegible] MITCHELL: Part of the terms of the Charter that we received from the Federal Government [illegible] a return [illegible] to the [illegible] of [illegible] certain [illegible] under the Companies Act [illegible] is too much of an innovation to [illegible] a [illegible] from the voluntary agencies [illegible] than [illegible] the form that the companies use in [illegible] their [illegible].

[illegible] the [illegible] and charitable, and [illegible] organization [illegible] even [illegible] without [illegible] of the Government or the Opposition [illegible], so if [illegible] that are [illegible], it seems to [illegible] [illegible] to the [illegible] of this [illegible].

[illegible] FULTON: Let us assume that this [illegible] were [illegible] and [illegible] it would [illegible] provide [illegible] with [illegible] to the [illegible] [illegible] and [illegible].

organizations, and as you know, most of the organizations in Canada in the voluntary field are provincially-organized groups. I am just wondering whether you would feel that this Commission might recommend the Federal Government encourage or try to persuade or induce or otherwise the provincial governments to follow a somewhat similar approach as the Federal Government itself might follow. This sort of approach is customary under the arrangements under Companies Act. The Federal Government may have federal companies and we have provincial statutes in this field but they are things that have taken many years and perhaps not quite evolved, there being an attempt for increasing uniformity.

Would you feel, once that is adopted at the federal level, we should go further and encourage similar development at the provincial level?

DR. ARMSTRONG: We feel if a voluntary agency is performing its functions adequately that it should be prepared to answer to the public in the form prescribed by the Government whether a provincial organization or a national organization and we feel this would prevent a lot of fly-by-night organizations unjustifiably going to the public for support.

MR. MACKLAIER: The practice I know is mandatory in Montreal, must be prevalent elsewhere, surely. As your Commission probably knows, in Montreal, before you get a permit to put on your next financial campaign you must have complied with the conditions of the previous permit that you file a return as to what

organizations, and as you know, most of the organization in Canada in the voluntary field are geographically-oriented groups. I am just wondering whether you would feel that this Commission might recommend to Federal Government consideration of ways to persuade or induce or encourage the provincial governments to provide somewhat similar support as the Federal Government does right below. This sort of approach is customary under the Arrangements under Companies Act. The Federal Government may have federal companies and we have provincial statutes in this field but they are things that have taken many years and perhaps not quite ev[illegible]ved, there being an element for increasing uniformity.

[illegible] you feel, once that is adopted at the federal level, we should go further on encouragement development at the provincial level?

[illegible]: We feel in a voluntary agency is performing its functions adequately that it should be preserved to answer to the public in the long procedure by the Government whether a provincial organization or a national organization and we feel this would prevent a lot of ill-by-night organizations unjustifiably going to the public for support.

[illegible]: The practice I know is laudatory on [illegible], must be overwhelmed sometimes. As your Commission probably knows, in Ontario, [illegible] a permit to get an [illegible] campaign you must have complied with the requirements of the provincial permit that you file a [illegible] to what

you received in the preceding campaign and the percentage of take to expenses and so on. That, in Montreal, I know is followed very rigidly and enforced strictly. There you are starting from the bottom up. It certainly works in Montreal.

COMMISSIONER FIRESTONE: Are these permits issued under provincial statute?

MR. MACKLAIER: No, under municipal by-law, Mr. Commissioner.

COMMISSIONER FIRESTONE: Is there no provincial legislation in existence in the Province of Quebec?

MR. MACKLAIER: I wouldn't like to be taken as giving anything but an off-the-cuff answer to that, which would be no, I don't think there is. The question asked is: is there any provincial Act, do you have to file in Quebec, do you have to file statistical returns on what was the fruit of your campaign and what did it cost you to raise the fruit and so on and so forth? I don't think there is but I know it is in Montreal and it works and it is very strictly enforced. I am sure Montreal is not unique in that respect.

DR. ARMSTRONG: In Alberta, there is some provincial legislation to that effect, but in Quebec we had a difficulty with one organization and we wanted to find out where the money was going and the only sort of control was this Montreal return.

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CHAIRMAN: FERRIGNO. Are these permits issued under provincial statutes?

Mr. MACKAY: No, under municipal

CHAIRMAN: PRICEMAN: Is there no provincial legislation in existence in the Province of Quebec?

Mr. MACKAY: I wouldn't like to be taken as giving anything but a off-the-cuff answer to that, which would be no, I don't think there is. The question asked is: Is there any prov model Act, do you have to file in Quebec, do you have to file statistical returns on what was the result of your campaign and what did it cost you to raise the fund and so on and so forth? I don't think there is but I know it is thought and it works and it is very strictly enforced I am sure Montreal is not unique in that respect.

Mr. MACKAY: In Alberta, there is some prov moral legislation to that effect. But it seems to have a difficulty with organizations and is worried to find out where the money was going and the only sort of control is the federal return.

DR. ARMSTRONG: We feel that this sanction would assist the responsible national organizations, and they could insist that their affiliates file an adequate return with the national, in order to complete a form like this.

COMMISSIONER FIRESTONE: What is the legislation in existence in Alberta?

DR. ARMSTRONG: It is a very rigid legislation, which goes to the other extreme where an organization is not allowed to appeal to the public without the specific permission, I don't know of what department, but of the government of the province. This is an almost undemocratic approach, that the government says you can appeal and you cannot appeal.

THE CHAIRMAN: Mr. Macklaier, do you think they can prohibit a dominion organization from carrying on business?

MR. MACKLAIER: We always get back to the constitutional question.

THE CHAIRMAN: Mr. Bennett and his Bonanza Creek business.

MR. MACKLAIER: It seems to me that if the federal government starts a thing like this from the top down, and the municipal governments start from the bottom, they are going to meet, and it becomes a packet.

COMMISSIONER GIRARD: Mr. Macklaier, knowing the difficulty that arises when you want to merge voluntary organizations, what difficulties do you anticipate, if any, in your proposed Canadian Council

[illegible]

[illegible]

[illegible]

for the Disabled?

MR. MACKLAIER: That almost sounds like a loaded question Miss Girard.

COMMISSIONER GIRARD: No, it is just that I come from Montreal, and I know how difficult it is to merge voluntary agencies.

MR. MACKLAIER: Well, I think Dr. Armstrong had better carry the main burden on this one. It is a tricky business in the sense that you are merging two federal organizations, but which in turn conduct mainly their functions through a series of provincial organizations, so you must in turn get the concurrence of the various provincial components, each of which is to a large extent autonomous, so it is a selling job which each federal organization has got to do down the line with its provincial affiliations, and that is the job which has undoubtedly been going on for some time, and which we all hope will come to a happy and successful ending next month at the meeting of both federal organizations in Ottawa.

DR. ARMSTRONG: This is a process that has been extended over several years, but we know that the other national groups are interested, and are sure of their co-operation and support once we get this basic structure established, but it is a long haul with many complications.

COMMISSIONER VAN WART: If government participates to a much larger extent in the field of health care, do you feel that your organization still has a voluntary place in the overall health picture?

for the Dominion?

MR. [illegible]: That almost sounds like a leading question this morning.

QUESTIONER CONTD: No, it is just that I come from Montreal, and I know how difficult it is to mesh voluntary [illegible].

MR. MACDONALD: Well, I think Mr. Armstrong had just to carry the main burden in this one. It is a tricky business in the sense that you are meshing two federal organizations, but which in turn combine mainly their functions through a series of provincial organizations, so you must in turn get the concurrence of the various provincial components, each of which is to a large extent autonomous, so it is a melting job which each federal organization has got to do down the line with its provincial affiliations, and that is the job which has not totally been going on for some time, and which we all see will come to a happy and successful ending next month at the meeting of both federal organizations in Ottawa.

MR. ASHLEY: [illegible] That is a process that has been going on over several years, but we know that the other [illegible] groups are interested, and are some of their co-operation and support once we get this [illegible] [illegible] [illegible], but it is a long haul to many [illegible].

PROFESSOR VAN WART: If government [illegible] [illegible] [illegible] in the field of research [illegible], do you feel that your organization still has a [illegible] role in the overall health [illegible]

DR. ARMSTRONG: We feel perhaps even more important than at the present time, because if we can establish a good partnership relationship between the interests of the ordinary citizen and his community club, or community agency, with the aims and objectives of the government, then good health care can become far more real to the people, not as though it is just passed on as it were through a government administrati system.

MR. MACKLAIER: I think from the point of view of government that is particularly federal government. I think their inclination is towards being able to deal with a federation like this, which can in turn work down into the provincial organizations. That I think has been Dr. Armstrong's experience ever since the inception of his connection with the Canadian Council. The bigger this is, the better the federal government is pleased, because then you bring the provincial organizations into contact with the federal government, as it were on a platter, and the more all-embracing that platter is, then the better we can deal effectively with the organizations right through the piece.

COMMISSIONER VAN WART: Would it have any effect on the collections for your Easter Seals?

DR. ARMSTRONG: I think you can only take the experience of England, where after national health service first came in there was a drop in voluntary support, and then the national health service itself began to encourage the voluntary effort, and now they are

Mr. MITCHELL: Is that perhaps even more important than at the present time, because if we can establish a good partnership relationship between the interests of the ordinary citizen and his community club, or community agency, with the aims and objectives of the government, then good health care can become far more real to the people, not as though it that passed on as it were through a government administrative system.

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Mr. CHAIRMAN: Would it have any effect on the collections for your Easter Seals?

Mr. MACDONALD: I think you can only make the experience of Canada, where after national health service first came in there was a drop in voluntary support, and then the national health service itself began to encourage the voluntary effort, and now they are

in the difficulty of so many groups having developed with the encouragement of government almost and the returns of these agencies have been on the increase over the last few years in a very marked degree, but England is trying to solve the same question that we are trying to solve. How can you maintain the right of a person to be interested in a specific interest, and at the same time have co-ordinated planning on a voluntary basis, so that the government isn't dealing with 150 different organizations, but there is one spokesman to reflect the voluntary agencies' point of view?

THE CHAIRMAN: Thank you very much gentlemen. We are indebted to you for attending here this morning, and for your brief, as well as this most pleasant discussion. Thank you very much.

DR. ARMSTRONG: Thank you sir.

THE SECRETARY: Mr. Chairman, the next submission, that of the Nova Scotia Rehabilitation Council, will not be presented by Mr. McVittie, who has advised me by letter this date that he cannot come forward to our Toronto hearings, and in view of this I suggest that the brief be entered as exhibit number 311, and that the summary of conclusions and recommendations contained at pages 2, 3 and 4 be part of the record, and that the letter from Mr. McVittie be also a part of the record.

---EXHIBIT NO. 311: Submission of the Nova Scotia Rehabilitation Council, Inc.

In the difficulty so many groups having developed with the government of government almost and the results of these agencies have been on the increase over the last few years in a very marked degree, but England is trying to solve the same question that we are trying to solve. Now can you claim in the right of a person to be interested in a research interest, and at the same time have non-sectarian planning on a voluntary basis, so that the government isn't dealing with 100 different organizations, but there is one spokesman to reflect the voluntary agencies' point of view?

Gentlemen, we are indebted to you for attending here this morning, and for your brief, as well as this most pleasant discussion. Thank you very much.

DR. ROTTRONG: Thank you sir.

MR. SECRETARY: Mr. Chairman, the next submission, that is the Nova Scotia Rehabilitation Council, will not be presented by Mr. Moffitte, who has advised me by letter that he cannot come forward to our Toronto hearings, but in view of this I suggest that the brief be entered as exhibit number 14, and that the summary of conclusions and recommendations contained at pages 2, 3 and 4 be part of the record, and that the letter from Mr. Moffitte be also a part of the record.

---EXHIBIT NO. 14: Submission of the Nova

SUBMISSION OF

THE NOVA SCOTIA REHABILITATION COUNCIL, INC.

Dear Major Lafrance:

You will recall our conversation during the public hearings on Monday, 7 May, when I informed you that representation for the Nova Scotia Rehabilitation Council before the Royal Commission on Thursday, 24 May, seemed unlikely.

I must inform you that there still seems to be no prospect for personal presentation of the Council's brief by any of our members. If this is the situation on Thursday, would you then arrange for the Council's brief to be "received" by the Royal Commission and to be placed in the records.

If, by chance, there is a request for copies from other sources, inquiries should be addressed to the Council's Secretary at 353 Bayers Road (Suite 15), Halifax.

The Council would be pleased to furnish information in supplement to the brief if the Royal Commission so desires.

Your co-operation is appreciated.

Yours truly,

(Signed) John I. McVittie
(Immediate Past President)
Nova Scotia Rehabilitation Council

SUMMARY OF CONCLUSIONS AND RECOMMENDATIONS

1. The historical development of rehabilitation services in Canada illustrates the importance of

[illegible]

[illegible] OF

[illegible]

You will recall our conversation during the public hearings on Monday, 7 May, when I informed you that representation for the Nova Scotia Rehabilitation Council before the Royal Commission on Thursday, 24 May, seemed unlikely.

I must inform you that there still seems to be no prospect for personal presentation of the Council's brief by any of our members. If this is the situation on Thursday, would you then arrange for the Council's brief to be "received" by the Royal Commission and to be placed in the records.

By chance, there is a request for copies from other agencies. Inquiries should be addressed to the Council's Secretary at 312 Lawrence Road (Lake Ia), Halifax.

The Council would be pleased to furnish information in supplement to the brief if the Royal Commission so desires.

Your co-operation is appreciated.

Yours truly,

(Signed) John I. Mackie
(Mackie Pen Pharmacy)
Nova Scotia Rehabilitation
Council

[illegible] OF [illegible] AND ECONOMICS:

1. [illegible] development of rehabilitation services in Nova Scotia, the importance of

pioneering by voluntary organizations and the typically Canadian pattern of joint action by public and private agencies, to the point where demonstration of need and experiment on various fronts result often in the assumption of responsibility by governments.

2. The provision of comprehensive rehabilitation services requires co-operation and integration for various medical, paramedical, and other professional, semi-professional, and technical resources, together with close and continuing liaison among government agencies, voluntary associations, hospitals, and other bodies.

3. Regulations on government grants towards capital costs of rehabilitation centres should take into account the special requirements for extensive out-patient and teaching facilities, and also the "regional constituency" areas served by these specialized hospitals.

4. Present facilities in Nova Scotia for production of special footwear and braces for rehabilitants should be extended to include research, design, manufacture, and fitting of artificial limbs for non-veteran rehabilitants. Current policies on grants should be continued, subject to study of payment for prosthetic devices.

5. Financing the legitimate costs of high-quality hospital services requires more realistic attitudes in policy formulation and in administration of public and private insurance plans, in the view of responsible hospital boards.

pioneering in voluntary organizations and the typically Canadian pattern of joint action by public and private agencies, to the point where demonstration of need and encouragement on various fronts result often in the assumption of responsibility by government.

2. The provision of comprehensive rehabilitation services requires co-operation and integration from various medical, paramedical, and other professional, semi-professional, and technical resources, together with close and continuing liaison among government agencies, voluntary associations, hospitals, and other bodies.

3. Regulations on government grants towards capital costs of rehabilitation centres should take into account the very high requirements for extensive out-patient and vocational facilities, and also the "regional constituency" cases served by these specialized centres.

4. Present facilities in Nova Scotia for production of artificial footwear and braces for rehabilitants should be enhanced to include research, design, manufacture, and fitting of artificial limbs for non-veteran rehabilitants. Consumer policies on prices should be monitored, subject to study of payment for prosthetic devices.

5. Lowering the inpatient costs of diagnostically focused services requires more realistic attitudes in public institutions and in the mistaken of public and private insurance plans, in the view of responsible medical opinion.

6. Further development of rehabilitation services will require the training of additional specialists in medical, paramedical, technical, and ancillary occupations. Continuation and expansion of programs for recruitment, training, and financial assistance are essential.

7. A comprehensive program for rehabilitation services requires establishment of assistance plans for transportation of out-patients attending clinics, rehabilitants taking approved courses, and consultants attending out-of-town clinics and patients, and also assistance towards capital and operating costs of low-rent hostels.

8. Requirements for in-patient beds and out-patient clinic facilities should be supplemented by further development of field services to patients in their own homes, a program involving assistance towards transportation costs and acquisition of mobile equipment.

9. Rehabilitation of employable individuals is complete only when suitable employment has been secured.

(1) Present assistance plans intraining should be continued and expanded.

(2) The proved value of sheltered workshops for conditioning selected rehabilitants merits assistance towards capital and operating costs of these facilities.

(3) Special placement services for employable rehabilitants require reorganization and expansion.

6. Further development of rehabilitation services is required, including the training of additional specialists in medical, paramedical, technical, and auxiliary occupations. Orientation and expansion of [illegible] assistance are essential.

7. A comprehensive program for rehabilitation services includes establishment of assistance plans for [illegible] of out-patients attending clinics, rehabilitants taking approved courses, and consultants attending out-of-town clinics and patients, and also assistance towards capital and operating costs of low-[illegible].

8. Requirements for in-patient beds and out-patient clinic facilities should be supplemented by further development of field services to patients in their own homes, a program involving assistance towards transportation costs and acquisition of mobile equipment.

9. Rehabilitation of employable individuals is complete only when suitable employment has been secured.

(i) Present assistance plans intending employers should be continued and expanded.

(ii) The proven value of sheltered workshops for conditioning selected rehabilitants with assistance towards capital and operating costs of these facilities.

(iii) Additional placement services for employable rehabilitants, including orientation and [illegible].

(4) Public education on employment of rehabilitants requires extensive and continuing attention.

10. The cost-of-living for rehabilitants is often higher than for other citizens, indicating the desirability of eliminating the means-test on earned income in connection with rehabilitants' pensions and allowances.

11. The use of public buildings by rehabilitants and other tax-paying handicapped citizens should be facilitated by street-level or ramped entrances.

THE SECRETARY: The next submission will be that of the Canadian Association of Physical Medicine and Rehabilitation, to be known as exhibit number 312.

---EXHIBIT NO. 312: Submission of the Canadian Association of Physical Medicine and Rehabilitation.

THE CHAIRMAN: We will have a short recess at this point.

---A short recess.

THE CHAIRMAN: Well, if we may come to order ladies and gentlemen, we will proceed.

(4) Public education on employment of rehabilitants versus provides extensive and continuing attention.

10. The cost-of-living for rehabilitants is often higher than non-other citizens, indicating the desirability of eliminating the means-test or earned income in connection with rehabilitants' pensions and allowances.

11. The use of public buildings by rehabilitants and other tax-paying handicapped citizens should be facilitated by street-level or ramped entrances.

THE SECRETARY: The next submission will be that of the Canadian Association of Physical Medicine and Rehabilitation, to be known as exhibit [illegible].

---EXHIBIT No. [illegible]: Submission of the Canadian Association of Physical Medicine and Rehabilitation.

MR. CHAIRMAN: We will have a short recess at this point.

---Short recess.

THE CHAIRMAN: Well, if we can come to order ladies and gentlemen, we will proceed.

SUBMISSION OF

CANADIAN ASSOCIATION OF PHYSICAL MEDICINE AND REHABILITATION

APPEARANCES:

Dr. G. A. Lawson
Dr. J.S. Crawford
Dr. J. Berkeley
Dr. A.T. Jousse
Dr. T.E. Hunt
Dr. W.O. Geisler

DR. LAWSON: Mr. Chairman, I am Dr. Lawson. I am President of the Canadian Association of Physical Medicine and Rehabilitation. Dr. J. S. Crawford, at the far end, Toronto; Dr. J. Berkeley, of Windsor; Dr. T.E.Hunt, of Saskatoon; Dr. A.T. Jousse of Toronto; and Dr. William Geisler of Toronto. Dr. Geisler is the Secretary of the Association.

THE CHAIRMAN: Dr. Gingras was unable to come?

DR. LAWSON: No, we are sorry he was unable to.

THE CHAIRMAN: Yes Dr. Lawson?

DR. LAWSON: We are happy for the privilege of presenting our brief, and I would ask Dr. Hunt, who was the Chairman of the Committee who drew up this brief, to present the brief.

DR. HUNT: Mr. Chairman, I wondered how you would request that I present this to you. I had felt that rather than read over recommendations with which your Commission must feel rather tired by now, that I might comment on some of the points that we would like to stress, and then go through some of the main items with you, if that is agreeable sir?

MINUTES OF

CONVENTION ASSOCIATION OF PHYSICAL EDUCATION ADMINISTRATORS

PRESENT:

Dr. A. H. Larson
Dr. J. G. Crawford
Mr. J. Kennedy
Mr. J. Lowes
Mr. W. H. Hunt
Mr. W. G. Reisler

THE CHAIRMAN: Mr. Chairman, I am Mr. Larson. I am President of the Canadian Association of Physical Education Administrators.

At the 1[illegible] end, Dean to, Mr. J. Kennedy, of Windsor; Mr. W. H. Hunt, of Hamilton; Mr. A. [illegible], Dean of Women; and Mr. Reisler of Toronto. Mr. Reisler is the Secretary of the Association.

THE CHAIRMAN: Mr. Chairman was unable to come.

MR. LARSON: No, we are sorry he was unable to.

MR. LARSON: We are here for the purpose of discussing our lists, and I would ask Mr. Hunt, who was the chairman of the Committee who drew up this list, to introduce the topic.

MR. HUNT: Mr. Chairman, I wonder how we could propose that I present this to you. I had sent that letter then and over [illegible] which [illegible] suggestion that I rather thought by now that I might consult on some of the items that we would like to report, and then to discuss some of the [illegible] with you. I think is [illegible]

THE CHAIRMAN: Whichever way you wish to do it.

DR. HUNT: We are particularly concerned that those seeking to know the problems of health services realize and recognize the great problem which is created by a group of patients, who we might call the chronics or those suffering from long term illness, severe disabling injury, and from the effects of aging.

We are concerned that there be realized that the problems these people face cannot be wholly solved by the provision of medical services alone, or by the coverage of medical services by some type of insurance alone. Their problems go far deeper than do these various types of services indicate. These people require co-operative services, as you already have heard from many, many individuals. This is the first point which I think we would stress. It is the first point in our summary of recommendations, on page 3.

We have outlined in our brief, in the succeeding pages from page 3, the various comments as to the services which have been developed. These, I am sure, you are quite aware of by now. Our only point is that we feel that any expansion, which is certainly needed, should be developed within present frameworks to provide services and hospital services, educational and welfare services.

Our main point in coming to you, however, is to stress the problems which we have in

THE CHAIRMAN: Whichever way you wish to do it.

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We have outlined in our [illegible], in the succeeding pages from page 5, the various comments as to the services which have been developed. These, I am sure, you are quite aware of by now. Our only point is that we feel that any expansion, which is certainly needed, should be developed within present frameworks to provide services and hospital services, educational and welfare services.

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personnel. We need a lot of workers, which we don't have. You are going to hear some of the paramedical shortages this afternoon from the Canadian Conference on Physiotherapy.

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BL/ss

We would like to point out that in addition to the extreme shortages of physiotherapists there are extreme shortages of all types of workers in this field. Be that as it may, the main concern is with the physicians' services in the rehabilitation field, and this involves both the general doctor or the average specialist and the specialist in physical medicine and rehabilitation.

Considering the problem of the former first, the general practitioner, on whose shoulders the brunt of care of these people falls, unfortunately at the present time he hasn't available to him the facilities to look after these people, nor has he had in the past adequate training. Finally, and probably of least importance, with this group of patients he really doesn't obtain adequate financial remuneration for their care. An ordinary house call for acute tonsilitis can take perhaps fifteen, twenty minutes of the doctor's time, and he may not do any procedures when he visits the patient with a chronic illness or a disability requiring rehabilitation, but he may spend as much as half an hour or an hour with the patient's family sorting out accommodation in the hospital, and so on.

Now, we have made some recommendations and commets --- our comments are on Page 7 and the recommendations on Page 9 --- trying to obviate this condition, particularly with regard to training the average doctor so he can do more in the care of this group of patients. We feel that the average doctor, as he goes through medical college and reaches interneship,

We would like to point out that in addition to the extreme shortages of physiotherapists there are extreme shortages of all types of workers in this field. Be that as it may, the main concern is with the physicians' services in the rehabilitation field, and this involves both the general doctor or the average specialist and the specialist in physical medicine and rehabilitation.

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Now, we have made some recommendations on page 7 and the comments -- our comments are on page 7 and the recommendations on page 9 -- trying to relate this condition, particularly with regard to training the average doctor, as he can do more in the care of this group of patients. We feel that the average doctor, as he does treating medical illness and problems in general,

has not had enough practical experience and responsibility to look after this type of person. We would recommend that any type of educational benefits accruing from your studies should take this into account. Compulsory rotation through rehabilitation service is one of the things we would suggest for medical students and internes. In the United States the Office of Vocational Rehabilitation has provided grants so that problems in teaching in chronic illnesses and rehabilitation can be further studied and augmented. Perhaps this is possible through Dominion-Provincial sponsorship in medicine.

THE CHAIRMAN: You know there is one underway under Dr. MacFarlane, through distinguished medical college deans, and so forth. This is the kind of recommendation which would go directly to that group, initially I mean.

DR. HUNT: Now, if we are to expand services for the chronically ill, including rehabilitation services, one of the things is that we need men who are expert in rehabilitation techniques and in the practice of medicine. We have been extremely concerned with the lack of our numbers.

THE CHAIRMAN: 51 in Canada in 1961.

DR. HUNT: This is not the smallest group of specialists but it is the smallest group which have such large responsibility. We tried to find out some of the reasons why there are so few of us and we took the liberty of carrying out a study on our own, which we have presented in Appendix B, and this is starting on Page 39. We tried to find out what medical

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[illegible] In conclusion [illegible]

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students and junior internes felt about this type of work. We tried to find out what type of work they were mainly interested in, what they felt about the various specialties and what they felt some of the bad points were of specialties they didn't like, and we were not surprised to find they didn't like our specialty.

We were a little surprised with some of the answers they gave as to why they didn't like it. As was expected, a large number was interested in general practice, a very large number was interested and wanted to specialize in internal medicine, and to a lesser extent in surgery. If you look at Table III on Page 42, this will give you some idea of the preference scale. We took the total number of preferences -- I don't know Dr. Firestone, whether this is good statistics or not, to take it at one hundred percent, but we took it at one hundred percent. You can see for physical medicine and rehabilitation, 1.2. Hospital administration was the lowest preference specialty below ours. Some of the answers are seen in Tables IV and V; the factors which they liked in a specialty are shown on Table IV.

The question which we asked the students was a very open one on this latter point, and although it was worded in terms of prestige, they could answer on what their colleagues felt, their teacher felt on it and the way the public viewed the specialty. The greatest thing was that they didn't think the work was important, it was routine and non-stimulating. They also realized it was of low value in the public eye, they really hadn't heard about this type of work.

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Interestingly, salaries played a very little, or income played a very little part.

Now, we compared the findings of the study with other literature which was available. I have noted some references on Page 41. Very much the same results were found in the United States by the workers whose references are quoted.

We then conducted a survey amongst our own group who had been practising a specialty for one or more years who are members of our Association. Not all the 51 who were quoted in the Royal College figures are members of the Association, but only 40 of them were selected. This was largely because my list of my colleagues was a year or two out of date. But it gave us the fact that they had been practising for some time in a specialty and 31 of them completed their replies.

Very, very few of our number have come up through student days and junior interneship days expecting to be specialists in physical medicine. Rather, there has been a change, sometimes after many years. I have quoted in the summary the average number of years of practice in our group is eighteen years. You can see that we are a very experienced bunch of medical practitioners, and more than half of this time has been spent in other types of practice.

The interesting reasons for our group becoming interested in rehabilitation are listed under the second part of Table VII on Page 46. In other words, the chance for a direct opportunity to develop, a challenging new field. Very often the specialist had

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The interesting reasons for our group becoming interested in rehabilitation are listed under the second part of table [illegible]. In other words, the drive for a direct opportunity to develop a challenging new field. Very often the specialist has

been working, say, in internal medicine and his colleagues in the medical school or city had said: "How about developing rehabilitation services?" and he had become interested in taking the necessary training. The opportunity arose for many of our number when they were in the Armed Services in the Second World War, and it was by this example that most of our members became interested in our specialty.

We have also listed some information on how they are working; some are in private practice, some working either full-time or part-time with an institution.

THE CHAIRMAN: I suppose that is sort of inevitable in the specialty.

DR. HUNT: I think it is, sir, with a large number. We feel from the results of the studies that recruitment of specialists in physical medicine can be expected to occur in two ways. One is through the method I have suggested of better exposure to this type of work with students and internes, but perhaps even better exposure and direction of interest after they have started training in some other field. Just how this is to be accomplished we don't know yet.

THE CHAIRMAN: Or from the general practitioner himself?

DR. HUNT: Who may become interested. We have made a suggestion, sir, that one of the things that might come out of our presentation to you would be a study of some of these problems on a more organized basis than a small society was able to carry out.

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THE CHAIRMAN: Dr. [illegible]

[illegible]

We have made a suggestion, sir, that one of the things that might come out of our presentation to you would be a study of some of these problems on a more organized basis than a sub-committee of this group to carry out

THE CHAIRMAN: I must say that this survey that you gentlemen have made appears to be exceedingly good and most useful and can be the starting point of other surveys. We have, as you know, a medical manpower and recruitment, and so forth, survey underway, and while at the moment I can't spell out the details, this question of the specialties is within the ambit of that study.

DR. HUNT: I knew you had a survey in mental health, but I didn't know about the other.

THE CHAIRMAN: We have several of them going. Some of them don't get as much publicity, such as the income one where we had to publish special letters.

DR. HUNT: One of the things we feel very strongly, and I might conclude on this point, and that is if we are going to entice men into the field, not only must their work be made interesting for them by providing more clinical work and less administrative work and providing research facilities, as we have mentioned, we do feel from our study of our own men who seem to be satisfied --- and I didn't include this in, but I can give it to you if you wish later--- that there is a need for retaining some private practice responsibility. Those who have this opportunity seem to be more satisfied than those who are full-time institutional workers.

MR. MARKMAN: I must say that this survey that you particularly have appears to be eminently good and most useful and can be the starting point of other surveys. We have, as you know, a medical mapping and recruitment, and so forth, survey underway, and while at the moment I can't [illegible] out the details, this question of the specialties is within the ambit of that study.

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H/dpw

THE CHAIRMAN: On that point itself, just what are the opportunities for private practice having regard to the nature of the individuals, the problems of the individuals with whom the specialty must deal in great measure?

DR. BERKELEY: Well, Mr. Chairman, I hung my shingle up in Windsor, a fairly small town of 150,000, nine years ago and I hoped that I would get people referred to me. I also had the opportunity to be a part-time consultant and this was very fortunate.

THE CHAIRMAN: Part-time consultant with -?

DR. BERKELEY: With two institutions; one chronic disease hospital that wanted to begin a program of rehabilitation for the old-age group and one cerebral palsy and out-patient treatment centre. I am one of those who has worked in other aspects of medicine; I have had a very good type of life and it is my own feeling, at least, it has suited me, that this is one way to practise physical medicine. I get people referred to me from my colleagues, they come to my office for the mild cases.

I have therapists, I have put in equipment and the patients can come to my office and they can get mild treatment for mild conditions. Also, I have had the chance to help develop in my area, and this is not one of the big areas with large hospitals where you need a full-time man, and I am not in disagreement with this, but we have only got small hospitals, 300 beds, and one of them is less and they could not

MR. CLARIDGE: On that point is-it, just what are the opportunities for private practice having regard to the future of the individuals, the problems of the individuals with whom the specialty must deal in great measure?

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I have therapists, I have put in equipment and the patients can come to my office and they can get mild treatment for mild conditions. Now, I have had the chance to help develop in my area, as this is not one of the big areas with large hospitals where you need a full-time man, and I am not in a partnership with this, but we have only got small hospitals, 50 beds, and one of them is less and they could not

support a full-time man.

I have had a chance to work on the staff, I am a consultant, just like the chief of surgery, although I have a small section and I have helped develop these as a consultant.

I have also been the consultant at our out-patient centre. Publicly-funded patients can go there that cannot afford to pay. I would say I refer cases there who need the group program. The more difficult cases, the cases who come to my office privately, they do not overcrowd the out-patient centres that are already overcrowded, already short of staff. There are some people who like to go to some other place, perhaps they may not like me, my therapist may not get on with them or there is a little bit of competition.

I have put in a new piece of apparatus owing to the fact that the hospital has put in a new piece of apparatus and the hospital therapist and I are in competition for the mild cases.

In summary, I think one tends to think that what suits me would be good for everybody else but I know this is not the case. I do have a vested interest, not only in equipment but also in treatment and this is what I feel a happy way to practise.

I think young doctors who may be considering this might want to develop rehabilitative services if they could practise something like the way I am practising, I think they might like it.

I think, frankly, if there is to be an

support a full-time man.

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I think some doctors who may be considering this must want to develop private services if they could practise something like the way I am practising. I think they might like it.

I think, finally, there is to be an

insurance program to pay for the costs and a lot of the people I see are poor and crippled, not all of them but some are and they need that type of program and they need a hospital program too, but if this is to be I would hope personally it would not be exclusively based on the hospitals or on the large areas. If that were to be the case my type of work would be squeezed out because who would come to me and pay for it if they can go to a hospital or a rehab. centre for a mild condition and get it treated free?

I would hope there would be approved centres in which they could get treatment.

THE CHAIRMAN: How do you deal with the matter of transportation? You say you are dealing with mild cases; you are necessarily dealing with ambulatory cases?

DR. BERKELEY: Yes.

THE CHAIRMAN: And do you say your private practice in the sense you have described it is limited to the segment of the people to whom your specialty appeals?

DR. BERKELEY: Yes, that would be the patients with painful neck problems such as after car accidents, shoulder, back, hand disabilities, crushing injuries, feet disabilities, painful hips; these are the ones who are able to get around and there are no other problems, no social problems because they can usually get back to work.

THE CHAIRMAN: You are in Windsor and we have heard quite a lot about Windsor which is perhaps

insurance premiums to pay for the costs and a lot of the people I see are poor and crippled, not all of them but some are and they need that type of program and they need a hospital program too, but if this is to be I would hope personally it would not be exclusively based on the population or on the large areas. If that were to be the case my type of work would be squeezed out because who would come to me and pay for it if they can go to a hospital or a rehab. centre for a mild condition and get it treated free?

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MR. CHALMERS: How do you deal with the matter of transportation? You say you are dealing with mild cases; you are necessarily dealing with ambulatory cases?

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MR. CHALMERS: And do you say your private practice in the cases you have described it is limited to the segment of the people to whom you [illegible]?

MR. BRADLEY: Yes. They would be the people with painful [illegible] problems such as after car [illegible], [illegible], [illegible] injuries, feet disabilities, painful hips: there are the ones who are able to get around and there are no other problems, no see al problems because they can easily get back to work.

MR. CHALMERS: You are in Windsor and we have heard quite a lot about Windsor; what is coming

one of the most progressive areas in Canada so far as medical services. You have worked with the prepaid medical plans there which are more universal in Windsor than any other place in Canada.

DR. BERKELEY: It has worked very well for me in my experience.

THE CHAIRMAN: And this type of thing is covered by the Windsor Medical?

DR. BERKELEY: My own medical services are physiotherapy and the patients pay themselves.

THE CHAIRMAN: That is for the physiotherapy part?

DR. BERKELEY: Yes, the physiotherapy part.

THE CHAIRMAN: What is your view? Do you think you could separate one from the other in terms of treatment?

DR. BERKELEY: Well, when I went there first, and the Windsor Medical people talked to me and they wondered whether they should include physiotherapy and asked what I thought. Well, I thought then, and I still think, it is the same as a drug, at least, it is very similar today; if you insure drugs it is a cost prescribed by a doctor and dispensed by a pharmacist and physiotherapy is the same thing.

THE CHAIRMAN: Of course, you have the Green Shield Plan for drugs in Windsor?

DR. BERKELEY: Yes.

DR. HUNT: I think Dr. Berkeley has hit on a very important point that we need to get across

in teaching programs and that is physical medicine is a prescription the same as a medical prescription. I would just like to interject that at this point.

Dr. Crawford is also doing institutional and private practice work so perhaps he could add a point here?

THE CHAIRMAN: You have a foot in both camps.

DR. CRAWFORD: I am in Toronto at the Western Hospital and the way that I work at the hospital is having my office across the street and also being Director of the Department of Rehabilitative Medicine at the hospital. I prefer to have it that my entire salary does not come from the hospital work but I have a chance to do private practice work as well.

I think there is a certain stimulus in this. I think my work can be more varied and I have a chance to look after patients of my own. As time has gone on I find that the referring practice was increasing more and more in this hospital than it ever had in physical medicine prior to this. They knew very little about it and at the present time the referring practice - doctors ask me to discuss problems with regard to diagnosis and how should they be handled and this has increased more and more. This is not only in hospital but outside the hospital.

Our institutional work in the hospital is increasing the same and we have had to take on more staff. This is a hospital of 750 beds. Of course it is becoming a difficult problem with me and I know it

[illegible]

[illegible]

[illegible]

is in other hospitals when you have your private work and your institutional work you ask what is the hospital paying for; is it paying for me to see the department is run the best way it should be run, that the therapists are doing the best work in relation to the type of disease, to assist them to see that they understand this disease?

In other words, to make the work more interesting for them. I think that probably is my main responsibility as far as the hospital is concerned, and that has increased and become more important. One thing I do at our hospital which is perhaps not necessary to do but I see every patient who is receiving physiotherapy treatment, whether I am asked to or not. This has been accepted and the doctors wish it that way.

I do not know that I can add anything more. We have this department for opportunities for rehabilitation and I look at it as a hospital service branch.

We have also developed a home service program where we can follow the patient when they leave the hospital and go to the home to see them, sending a physiotherapist with an equipped vehicle. We feel the transfer from hospital to home is sometimes a tremendous jolt for many of our patients who are chronically ill; they have been in a lovely environment where a nurse has been waiting on them and the meals were all prepared and suddenly they find themselves in a situation where they have to face the problem of the home and the children and the wear-and-tear problems

which everybody has at home.

We find we can correlate with other facilities in the community, go into the home and seeing that patient and carrying on the work in the hospital that the patient had before she left. It makes it a little easier and the follow-up program makes things easier for her to carry on.

THE CHAIRMAN: Now, we have two types; we have Windsor with 150,000, perhaps a little more, and the metropolitan Toronto area. Now, Dr. Hunt, you have a situation in Saskatoon, a smaller city again.

DR. HUNT: Not very much.

THE CHAIRMAN: I am just talking about the physical end of it.

DR. HUNT: One of our problems; we are very limited in private work. We do have some which do not fall into either of the categories mentioned, work for organizations for which we are allowed to charge and the money goes to our department.

The point I would like to make is to compare the work of a hospital department where the work is on sort of a budget plan compared to another department of the medical centre and the hospital in which fees for services are allowed which might follow on the amount of work done.

I think it is extremely important in a teaching centre because the department has earnings which can be increased by the amount of work done which is really the fee-for-service idea, and can do better, have monies available for research, for new

MR. [illegible] Yes, of course

[illegible] and we can score six in other facilities in the community, go into the home and secure that entirely independent on the work in the hospital that the patient has before she left. It makes it a little easier for the follow-up program. Make things easier for her to carry on.

MR. [illegible]: Now, we have two types, we have [illegible] 100,000, perhaps a little more, and the metropolitan [illegible] area. Now, Dr. Hunt, you have a situation in Saskatoon, a smaller city again.

MR. [illegible]: I am just thinking about the medical [illegible].

DR. HUNT: One of our problems, we are very limited in relative work. We do have some which do not fall into either of the categories mentioned, work for organizations for which we are allowed to receive the money goes to our department. The thing I would like to see is to encourage the [illegible] of a hospital department where the [illegible] is no [illegible] of a larger [illegible] composed to another department of the medical centre and the hospital in which [illegible] are [illegible] which might flow on the amount of work done.

I think it is extremely important in a [illegible] where the department has [illegible] which can be measured by the amount of work done which is [illegible] the [illegible] can do [illegible]. [illegible] the new

personnel if needed, have monies available for teaching in a department such as mine or some of the other departments in our hospital. We are dependent upon the hospital budget and I believe this is one of the reasons why research in physical medicine may have been somewhat limited in the past.

Funds are - particularly in our areas anyway - funds which are available to other departments for research and teaching are not available to us to the same extent and we cannot develop our program from the physician point of view. We cannot develop our research program because this must go through interminable Boards and Hospital Rate Boards and government before the money comes through, which means planning a long way in advance.

Then, you get the money and lose the personnel you had hoped to have to do the research work and you are caught whereas if you had monies of your own available you could hire people and get the work done. That is a comment I would like to make on this problem.

personnel of course, have morale and table for reading in a department and - mine - more or the other department in our hospitals. We are dependent upon our hospital budget and I believe this is one of the reasons why research - on clinical medicine may have been somewhat lagging in the past.

There are - just certainly in our areas anyway - funds that are available to other departments for research but they are not available to us to the same extent and we cannot develop a program from the physician point of view. We cannot develop our research programs because this must go through internal boards and hospital lab reports and government before the money comes through, which means planning a long way in advance.

Then, you get the money and lose the personnel you had hoped to have to do the research work and it is more difficult when if you had months of your own available, you could get a people and get the work done. This is a problem I would like to make on this program.

COMMISSIONER BALTZAN: Dr. Hunt, who pays for the patient's treatment in your department?

DR. HUNT: I suppose the Saskatchewan Hospital Service Plan as far as my services are concerned. If they come in as an in-patient the hospital plan pays for it. If they come in as out-patients they pay their own. This is sort of a ludicrous situation in our department where I might do a very complicated electro-diagnostic test on a patient's nerves and muscles using very complicated apparatus and knowledge which has been gained by a lot of study for nothing. Part of the treatment may include the use of the same type of apparatus but because the physiotherapist uses it, the patient pays for it. This doesn't lead to the inducement of people into the specialty.

COMMISSIONER VAN WART: Is there any province besides New Brunswick which pays for out-patient physiotherapy under the hospital plan?

DR. HUNT: This is in the Medical Insurance Act in Saskatchewan, but it hasn't been paid for yet.

COMMISSIONER VAN WART: There is no other province?

THE CHAIRMAN: It was announced but not implemented.

DR. HUNT: That is right. Dr. Jousse has a comment to make.

DR. JOUSSE: I would like to emphasize that despite the somewhat gloomy picture we have drawn with reference to rehabilitation and rehabilitation personnel,

[illegible]

[illegible] pays for the patient's treatment in your department?

MR. HUNT: I suppose the Saskatchewan hospital services plan as far as my services are concerned. If they come in as in-patients the hospital plan pays for it. If they come in as o[illegible]-patients they pay their own. This is sort of a ludicrous situation in our department where I might do a very complicated electro-diagnostic test on a patient's nerves and muscles using very complicated apparatus and knowledge which has been gained by a lot of study for nothing. Part of the treatment may include the use of the same type of apparatus but because the physiotherapist uses it, the patient pays for it. This doesn't lead to the improvement of people into the specialty.

MR. MISSIMER VAN WART: Is there any province besides New Brunswick which pays for out-patient physiotherapy on the hospital plan?

MR. HUNT: This is in the Medical Insurance Act in Saskatchewan, but it hasn't been paid for yet.

MR. MISSIMER VAN WART: There is no other province?

MR. HUNT: It was authorized but not implemented.

MR. HUNT: That is right. I'm [illegible] a comment to make.

MR. [illegible]: I would like to congratulate that despite the somewhat gloomy picture we have been with reference to rehabilitation and rehabilitation [illegible]

in actual fact the major portion of rehabilitation is and always has been carried out by individual physicians and surgeons who treat their patients and who never allow them to become dependent or allow their lives to be interrupted by illness or disability longer than is necessary.

Our teaching, and we have been teaching physical medicine and rehabilitation in Toronto for ten, twelve, fifteen years, and the lack of impact on successive generations of medical students may reflect poor quality of teaching, but I prefer, because I am involved to attribute it partly at least, to the fact that we haven't had one of the requirements that Dr. Hunt and the rest of us stipulated which is the opportunity to rotate house doctors through a department of physical medicine and rehabilitation, particularly a ward, where patients who require this type of treatment are assembled. This is because these wards, by and large, don't exist in general hospitals in Toronto. In other words, there are no beds in significant numbers set aside for care of patients who require this type of treatment of chronic disabling dis orders over a long period of time. I feel somehow the concern of the doctor must be aroused for the care of the patient at this stage so that doctors will assume responsibility for the long-term care. We have failed in that area and I think we would fail to a less marked degree if we had these facilities.

I think closely allied to this, as has been mentioned, is the desirability of private practice. In a private practice one is charged with the

[illegible]

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[illegible]

The physical [illegible] two residential [illegible] in Toronto for ten, twelve, fifteen years, and the loss of income or successive generations of medical students may reflect poor quality of teaching, but I prefer, because I am inclined to attribute it partly or least, to the fact that we have [illegible] one of the requirements that the [illegible] the rest of the stipulated which is the opportunity to [illegible] noise outside [illegible] a department or physical medicine and rehabilitation, particularly a ward where patients who require this type of treatment are [illegible]. This is [illegible] in the [illegible], [illegible] the general hospitals in Toronto. In addition, there are no beds in rehabilitation [illegible] or provide [illegible] of chronic [illegible] cases over a long period of time. I feel [illegible] the number of [illegible] must be [illegible] for the care of the [illegible] so that [illegible] will [illegible] facility for the [illegible] have failed to [illegible] and I think we need [illegible] [illegible] in [illegible] these [illegible]

[illegible]

has been [illegible] the [illegible] [illegible] [illegible] one of [illegible] with

responsibility of care for a patient directly. In institutional care very often the rehabilitation doctor does not assume full responsibility for the care of the patient. Perhaps inherent in the lack of impact of this aspect of medicine on medical students is this factor. I have been fortunate in being in the position I have many patients to care for.

I would like to point out that much of the teaching of rehabilitation medicine has been and is being done by physicians who are not directly involved, by surgeons, orthopaedic surgeons, neurosurgeons and others. There are many people requiring rehabilitation who do not require specific care, application of specific techniques of physical medicine, but they also require our care. Thank you very much.

COMMISSIONER BALTZAN: In your hospital you haven't got a separate department, Dr. Jousse, where you segregate your physically disabled for physiotherapy. In your hospital you say you have a department, Dr. Crawford.

DR. CRAWFORD: We have a separate department in our hospital. We have beds in the hospital but these beds are not specifically allocated or segregated as an area where patients may stay longer for rehabilitation procedures. Our problem in our hospital as in many other hospitals is I am being urged to get my patients out as soon as possible. In other words, I haven't long-term beds, but I have a separate department area.

COMMISSIONER BALTZAN: Is it because

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Dr. [illegible]: Is it because

nearly all hospitals are socalled acute hospitals?

DR. CRAWFORD: Yes, sir.

COMMISSIONER BALTZAN: And the type of patient that you get would be something like the individual with a coronary who has a frozen shoulder and in the interval of his cardiac treatment you look after this other complication.

DR. CRAWFORD: That is true.

COMMISSIONER BALTZAN: You are not getting cases referred as in-patients who are suffering from a specific handicap in terms of physical medicine.

DR. CRAWFORD: That is right. I suppose another problem is the patient with the stroke who is brought in and we are urged constantly, urged to get that patient as soon as possible while every doctor realizes the importance of getting that patient up and standing and walking, but please, please can't we get him moving somewhere so we can make the bed available for the coronary that is waiting to come in. We have to seek beds elsewhere, chronic disease or convalescent hospitals in the area. I am connected with the development of a convalescent hospital in Toronto that has just been finished called Hillcrest. I feel that type of bed should be as close as possible to our hospital. I think that is the only answer I can see at the present time for this problem that exists in acute hospitals.

COMMISSIONER BALTZAN: This sort of unit should be an adjunct to the acute hospital?

DR. CRAWFORD: I think so.

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CHAIRMAN: What the type of patient that you get would be something like the individual with a coronary who has a frozen shoulder and in the interval of his cardiac treatment you look after this other complication.

Mr. CHAMPION: That is true.

CHAIRMAN: You are not getting cases referred as ir-patients who are suffering from a specific handicap in terms of physical medicine.

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unit should be an annex to the acute hospital.

Mr. CHAMPION: I think we

COMMISSIONER BALTZAN: As we call them the general hospitals.

DR. CRAWFORD: Not necessarily right in the teaching or the acute hospital, but at least side by side where we will visit frequently, where we will be able to have referral back to acute care, laboratory, tests, investigation if necessary, because I don't think we should segregate physical medicine as a specialty that does not require consultation and association with problems of acute care.

COMMISSIONER BALTZAN: Isn't that sort of a haphazard thing so far as the department is concerned in relation to encouraging or interesting residents and internes to become people who will participate in the branch of physical medicine?

DR. CRAWFORD: Yes, I think that is true, sir.

COMMISSIONER BALTZAN: It is not a unit.

DR. CRAWFORD: No, it isn't a unit yet.

DR. JOUSSE: You asked me a question, sir, I operate in a unit for spinal cord, spinal cord injured patients and also in the Toronto General Hospital, and to a lesser extent Sunnybrooke. My reference to lack of beds was in the general hospital. In the Spinal Cord Unit we have beds for long-term care of patients without limiting really, as indicated by the needs of the patient.

COMMISSIONER BALTZAN: Dr. Berkeley, in carrying on your private practice do you require much in

COMMISSIONER [illegible]: As we said over the general news rate.

DR. [illegible]: Not necessarily right in the teaching or the [illegible] hospital, but at least side by side where we will [illegible] frequently, where we will be able to have referral back to [illegible] care, laboratory tests, investigations [illegible] necessary, because I don't think we should segregate physical medicine as a specialty that does not really [illegible] a association with problems of acute care.

[illegible] of a hopeless thing to say [illegible] the department is concerned in relation to encouraging or interesting residents and interns to become people who will participate in the [illegible] of physical medicine?

[illegible] true, sir.

COMMISSIONER [illegible]: It is not a [illegible].

DR. [illegible]: No, it isn't a unit yet.

DR. JOHN E. [illegible]: You asked me a question, sir, I operate in a unit for spinal cord, spinal cord injured patients [illegible] in the Toronto General Hospital, and to a lesser extent Lyndhurst. My reference to lack of [illegible] in the general hospital. In the [illegible] and that we have [illegible] for long-term care of [illegible] patients [illegible] really, as indicated by the needs of the patient.

In carrying on your private practice [illegible] you require back i

the way of equipment as will help you in doing the work you do on ambulatory patients?

DR. BERKELEY: So far as my medical work goes, and I do house visits, I used to take my medical bag with me and that gradually got less and less. Now when I go to see a patient at home I have got a roll of adhesive in my car. That is all. That is all I need in my private practice work, except when I get involved in electrodiagnostic tests which Dr.Hunt mentioned and for them I use the services of one of our general hospitals where we have this expensive equipment.

COMMISSIONER BALTZAN: In therapy, do you require physiotherapy and hydrotherapy?

DR. BERKELEY: I have purchased over the years quite extensive apparatus for deep heating and hydrotherapy and electrotherapy and I have got an occupational therapy program, work activity, plus the area needed for it.

COMMISSIONER BALTZAN: Which brings me to the next question: In relation to your private setup, Doctor, you require special personnel. Do you require many?

DR. BERKELEY: One and a half.

COMMISSIONER BALTZAN: One and a half, and that is one who is a physiotherapist?

DR. BERKELEY: One and a half registered physiotherapists and I also have a person who is occupational but is an aide, who is a non-qualified person and who helps with the work program.

COMMISSIONER BALTZAN: Dr. Hunt, it seems

[illegible]

[illegible] man or woman [illegible] in doing the work you do on this [illegible]?

[illegible]

Well yes, sir. I do [illegible] vitals, I need to take an medical [illegible] with me and that [illegible] get lots and lots, how when I go to see a patient [illegible] I have not a full of [illegible] [illegible]. But in all, that is all I need in my private practice work, except when I get involved in electrocardiographic tests which [illegible] mentioned and for them I use the services of one of our general hospitals where we have this expensive equipment.

COMMISSIONER BAITMAN: In therapy, do you use physiotherapy and hydrotherapy?

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DR. [illegible]: Yes and a [illegible] physiotherapists and I also have a person who is a [illegible] but is an aide, who is a non-qualified person and who helps with the work [illegible].

COMMISSIONER BAITMAN: Yes, but, it seems

the way your field is developing there are now rehabilitation centres of large magnitude and then there are departments in the hospitals and then we have heard about a combined thing of private practice plus part-time in hospitals and the fourth which probably combines all of them, that is the extension into home service. My question to you, Dr. Hunt, at this moment in relation to hospitals of two or three hundred beds, what is the minimum functional requirement for servicing, say, an acute post-traumatic case or the servicing of an acute post-apoplectic case and other things? We can't have in large hospitals, I do not think, a complete rounded out patient service which would be ideal.

DR. HUNT: I don't know where we draw the borderline, sir. I have been extremely interested in the bringing together of the problems of chronic illness and geriatrics and rehabilitation in all general hospitals by special wings. This involves arthritis, a number of things. In Saskatoon where we feel each of the three hospitals in Saskatoon should have units of perhaps up to 50 beds and this would solve our problem of geriatrics as well as other acute rehabilitation problems. Now, our hospitals, other two hospitals are in the category you mentioned 200 to 300 beds. I think it is a little easier to talk about a 150-bed hospital, Dr. Baltzan, and here I think you don't need the whole setup we have mentioned.

COMMISSIONER BALTZAN: This is exactly what I would to see reduced....

DR. HUNT: Through active physiotherapy departments. I have been fortunate to have some experience

the way your field is developing there are now rehabilitation centres or large rehabilitation centres then there are departments in the hospitals and then we have had about a combined thing of private practice plus part-time in hospitals and the fourth which probably combines all of them, that is the extension into home service. In relation to you, Mr. Hunt, at this moment in relation to hospitals of two - three hundred beds, what is the minimum functional requirement for service, say, an acute post-traumatic case or the servicing of an acute post-amputation case and other things? We can't have in large hospitals, I do not think, a complete rounded out patient service which would be ideal.

In the borderline, sir, I have been extremely interested in the bringing together of the problems of chronic illness and geriatrics and rehabilitation in all general hospitals by special wings. This involves activities, a number of things. In Saskatoon where we have much of the three hospitals in Saskatoon should have units of perhaps up to 50 beds and this would solve one problem of geriatrics as well as other acute rehabilitation problems. Now, our hospitals, other two hospitals are in the category you mentioned 200 to 400 beds. I think it is a little easier to talk about a 100 to 200 hospital, in addition, and here I think you don't need the whole setup in these institutions.

COMMISSIONER BAGNALL: This is exactly what I would to see happen.

Mr. HUNT: Though some are considerably

in this line in the City of North Battleford in Saskatchewan where the hospital has approximately 125 beds, and they have a very active physiotherapy department. And now, with proper training of nurses and physiotherapists and perhaps the hiring of an occupational therapist as well, I think the needs of the community can be met fairly well with a visiting consulting service.

In this line in the City of North Battleford in Saskatchewan where the hospital has approximately 115 beds, and they have a very active physiotherapy department. And now, with proposed training of nurses and physiotherapists and perhaps the hiring of an occupational therapist as well, I think the needs of the community can be met fairly well with a visiting consulting service.

dpw

You don't need a full-time physical medicine specialist in a city that size, or in a hospital that size. You probably don't need too much in the way of special beds, but there again, perhaps 10 beds which combine again the problems of geriatrics. Some of us were playing with figures one day and we felt that in Saskatchewan alone, if hospitals on a regional basis, such as North Battleford, had 10 beds they would be filled the whole year round with stroke cases alone, or, at least, cerebrovascular cases, which may not be strokes. So it varies from community to community.

I think that every hospital with 50 beds or more should have a physical medicine department if there is only one physiotherapist there.

COMMISSIONER BALTZAN: Well, the expert advice could be available through visits or consultations periodically, and keep the helpers or other workers in that department fully instructed?

DR. HUNT: That is right.

COMMISSIONER BALTZAN: And patients can get very adequate service, and what can be called a fairly modern approach to their problems?

DR. HUNT: In North Battleford it has been most interesting. Several years ago the Sisters made their first decision to hire a qualified physiotherapist. This was approximately four years ago now. They didn't think, neither the Sisters nor the medical staff felt that this person would be busy at all. This department has grown since there have been consulting

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services available, so now they are trying to find a third physiotherapist and a third attendant from one four years ago.

It just shows the amount of work that has to be done in these small centres, and how it can be done and how satisfying it is to the staff of the hospital to have it.

COMMISSIONER BALTZAN: Through that experience you can see an opportunity for decentralization, without reducing the actual quality of the modern approach to rehabilitation?

DR. HUNT: Oh, yes sir. We have many, many types of problems with which we deal, which the doctor without specialist training in physical medicine should be able to handle for his own community, and most strokes are examples of this.

COMMISSIONER BALTZAN: Dr. Hunt, your specialty is physiatrist. How old is that? When was it recognized by the Royal College?

DR. HUNT: Dr. Jousse says the first certification in the specialty in Canada was in 1948. Dr. Storm was one of the first practitioners of this type in Canada, and he was working before the Second World War and Dr. Gardner, of course, was head of the department in the Toronto General Hospital since some time in the 30's.

COMMISSIONER BALTZAN: Do you see a great likelihood of young men who are leaving their residency or during their residency, decide upon entering physical medicine, or do you think it will

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COMMISSIONER BARTMAN: Do you see a great likelihood of young men who are leaving their residency or during their residency, decide upon entering physical medicine, or do you think it will

still lie along previous lines, that the greater percentage of people who enter, or confine themselves to the practice, often this is after having done other work, then gravitate to this specialty?

DR. HUNT: This is an interesting question, because Dr. Cameron and I, since we made our survey, have been going after some of the residents in medicine, particularly in our own hospital, or assistant residents, and although we have not been successful this year, the interest has certainly been stimulated, and I think if we can assure these young men, particularly those with a broad background in general medicine and surgery, to come into our specialty, say, with three years training, to assure them of a reasonable type of working condition, a reasonable chance to do research, and a reasonable chance to lead a satisfactory life, that we will get them just from this little experience we have had since our survey has been completed. The interest is there.

COMMISSIONER BALTZAN: How much of the medical curriculum is being given in the way of instruction to inform the young people that this is an up-and-coming requirement for the good of the sick?

DR. HUNT: I don't know across Canada. In our own school we don't push ourselves as much as perhaps we might. We have a very good curriculum for instruction for the student in rehabilitation as it applies to the general practice of medicine, and we feel that this at that time is our job, that all doctors should have some grounding in it.

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COMMISSIONER BALTZAN: Yours is relatively new. The reason I asked that question is because we have heard others speak in terms of increasing the amount of time, the student's time, to devote himself to become knowledgeable in psychiatric problems.

Now, I see that you also want to increase the student's time to become knowledgeable in this ever-increasing field.

DR. HUNT: It is very hard to say -- I think most of us here are teachers, sir -- just how much time is optimum. We had over 100 hours at our school and we cut it down because we felt they were not getting enough general medicine.

On the other hand, I think a great deal of our teaching can be done in other people's time, if you get what I mean. The problems of the amputee should be stressed, not only by us, but by the surgeon who does the operation.

The problem of the paraplegic bladder should be stressed by the urologist.

COMMISSIONER BALTZAN: Just one final question; and that is, what are the special disciplines required of the man who enters upon the study of and the devotion to the practice of physical medicine? Must he have more time, say, in physics, electricity? What are the special disciplines?

DR. HUNT: That is very hard to say. I think the primary thing is he must be a good doctor.

COMMISSIONER BALTZAN: Exactly, because

[illegible]

[illegible]y now. The reason I asked that question is because we have been [illegible] speak in terms of increasing the amount of time, the opportune time, to devote himself to some knowledgable in psychiatric [illegible].

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The problem of the primarily [illegible] should be stressed by the [illegible].

Dr. [illegible] SANDZAK: Just one final question, and that is, what are the special [illegible] [illegible] of the man who enters upon the study of and the [illegible] to the practice of [illegible] medicine? Must he have some [illegible], or, in plain [illegible], [illegible] that are [illegible] [illegible]?

Dr. HUNT: That is very hard to say. I think the [illegible] is he must be a good [illegible], [illegible] [illegible]: [illegible] [illegible]

yesterday, listening to other people talking about the occupational therapists, the point came up that the physiatrist must be a physician, rather than a rehabilitationist. Now, on the other hand, the physiatrist, you say, must have certain disciplines. Now, what are those special disciplines?

DR. LAWSON: I have had 15 years general practice, and I look on physical medicine as the general practice of the specialists. I have to talk to the specialists and know about their routines, but you have to spend more time with your patients. I feel that every doctor is a good rehabilitationist. He is good at getting people back to work, but there are difficult cases that you need to spend more time with. The early talking to a patient, like having time again, Dr. Hunt stressed the fact you cannot do it in 20 minutes. You may have to spend an hour or an hour-and-a-half with the patient and the family.

So you have to be interested in long-term cases. It is based on a good diagnosis. You have to treat the right thing and treat it properly. So that your discipline is, well, you have to keep up as a physician. You have to keep up your general practice as a surgeon. You talk to orthopaedic people, to urologists, and it is a challenging and very wide field, and you cannot know everything as good as the other fellows, but you get a wide fund of knowledge and you get a basic line, and then you want to spread out and try and get these long-term people back and I feel it is important that a fellow that has some private

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practice -- I had for years, now I am restricted to just doing physical medicine, but if I hadn't had 15 years private practice I wouldn't know what it is like to be in a home, and the problems there.

The great thing is to start the fellow right off that he is going to get better. The average doctor does that and it is the difficult cases that we have to give him advice on.

2 DR. JOUSSE: There is one significant responsibility imposed on the shoulders of physiatrists, and that is the ability to evaluate the patient with a disability in terms of what the disability means to him, to his family, to his working future and then to plan with him the program which will minimize, or help to circumvent, the disability.

I think if there is one skill, one stock-in-trade, it is that aspect of evaluation.

DR. HUNT: I think there is another important thing, and that is that the average doctor, as he practises either general or specialty work, practises largely on his own. He works by his own head and his own hands. He gives a prescription, which the patient takes to a drugstore, or he slates an operation, and takes out stitches.

The physician who does physical medicine and rehabilitation must know of an extreme number of resources available for his patients. He must know, in Saskatchewan, for example, how to get an artificial limb made through the Red Cross, by the D.V.A., to be paid for by the local municipality. All sorts of

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Dr. Wolff: I think there is another important thing, and that is that the average doctor, so he practises either general or a specialty work, practises largely on his own. He works by his own head and his own hands. He gives a prescription, when the patient turns to a druggists, or he sets an operation, and is out at it.

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odd twists to get services for his patients, which the average doctor does not know, and I think the discipline, or mind to accept a certain amount of humdrum administration and deviation of channels, so to speak.

I think most of the others would agree with me that we do spend a lot of time working on other services than our own for our patients.

COMMISSIONER BALTZAN: I am only driving towards one point ---

THE CHAIRMAN: This discussion is most interesting, but it seems to be beyond the scope of our inquiry.

COMMISSIONER BALTZAN: You mentioned here that you need one physiatrist for 50,000 patients, or people, and you have a great shortage and a great difficulty in getting people prepared for that. I want to see in what extent a specialist can extend himself over a wide population. That is what I am driving at.

DR. HUNT: Well, as you see in our submission, we vary between one in 50,000 and one in 100,000. It is very difficult to estimate just how many are necessary. Dr. Gingras has made a very good survey of the Montreal district and this figure of one in 50,000 is his.

We feel that perhaps 10 are needed in Saskatchewan, again a place where we have made a pretty detailed survey of our needs because of another committee's requirements, and we feel we need at least

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[illegible] BURRAN: You mentioned [illegible] or people, and you have a great shortage and a great difficulty in getting people prepared for that. I want to say in what extent a specialist can extend himself over a wide population. That is what I am driving at.

Dr. DUNN: Well, as you are in our [illegible], we vary between one in 5,000 and one in 100,000. It is very difficult to estimate what now many are necessary. Dr. Gregory has made a very good survey of the Montreal district and this figure of one in 50,000 is [illegible].

We feel that perhaps [illegible] in the region of [illegible], again a place where we have made a pretty detailed survey of our needs because of the [illegible] committee's recent report, and we feel we need at least

10, so this puts us at one to 100,000 people, not patients, populace.

DR. BERKELEY: In the matter of discipline, I think there are two aspects. If you want the physiatrist to be an organizer, he is an organizer and he can organize for his area. For instance, I try to organize; I have appointments at four general hospitals, one chronic disease, the Ontario Hospital School for Remedial Speech, and the local rehabilitation centre.

I also think there is a clinical aspect, and in the discipline there, if I were to pick up one thing it would be mechanical problems in the soft tissues.

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/dpw

I feel personally that this would be a challenge and that is why it is hard to describe, because you can't x-ray soft tissue. But we see them as physiatrists, at least I do, parts of the body that don't move as much as they ought to or they are not as strong as they ought to be and therefore there is a mechanical aspect that I think the young doctor ought to have and an interest and I think he should have the ability to see the rhythm and the problems. If you have a weakness, what does that mean in terms of use of that part - almost as a time job analysis.

There is a part of it, there is a very detailed, non-emotional aspect. So it is a big challenge, and it may be possible that if one man isn't a good organizer and a good detail man at the same time, perhaps it may develop where there will be a clinical aspect to our work and there will be a rehabilitation, co-ordinating, organizational, institutional aspect.

COMMISSIONER FIRESTONE: Dr. Lawson, Dr. Hunt, in paragraph 1 of your summary and recommendations, you say:

> "That recognition be given to the increasing problems in health care created by chronic or protracted illness and disability, and by the aging processes."

What would you say are the major factors contributing to what you call increasing problems created by chronic illness or protracted illness? One

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Dr. Hunt, in paragraph 1 of your summary and recommendations, you say:

> "That recognition be given to the increasing problems in health care created by chronic or prolonged illness and disability, and by the aging processes."

What would you say are the major factors contributing to what you call increasing problems created by chronic illness or prolonged illness? One

factor is quite obvious and that is with reference to the aging process; as we have more older people the incidence will present more patients in that group. But what is the position with respect to people in the 65-year and under group as far as the incidence of the type of diseases you are talking about?

DR. HUNT: Well, there are two things which are very important. One is the traumatic problems. Our highways are bringing more people to us for treatment, but they are also creating more patients, industrial accidents and so forth, which, in the past, would have been fatal.

Take the paraplegic patient. Before the Second World Ward, if a person was involved in a car accident and the spine was fractured and the spinal cord cut, that person's life expectancy was a month. Now, with the rehabilitation care, care of his bladder, it means that he can live almost as long as an uninjured person.

There are some records to show that insurance companies are accepting these people with very little increase in rates.

Now, these people who previously would have died because of serious injury are living and living with an injury which needs care afterwards.

COMMISSIONER FIRESTONE: You have dealt with a group experiencing accidents on the road, occupational hazards, but how about other incidents?

DR. HUNT: There is heart disease, rheumatic disease, strokes, which occur in older people.

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CHAIRMAN FLETCHER: You have dealt with a group experiencing accidents on the road, occupational hazards, but how about other incidents?

Dr. HUNT: There is heart disease, rheumatic disease, strokes, which occur in older people.

We certainly seem to be seeing more cancer in younger people.

Now, a lot of those cancers may be treatable or treatable for a greater length of time; and there are people with cancer of the brain who may live for 5 or 6 years and with proper care, we have them up and about and at home.

COMMISSIONER FIRESTONE: When you speak of old people, you are referring to increasing incidence or more people in absolute numbers?

DR. HUNT: I think it is both. People are living longer and we are getting an increased incidence of these illnesses.

COMMISSIONER FIRESTONE: In other words, your problem, if I understand you correctly, is a growing one in all age groups; it is not only the aging groups but the younger groups as well, and therefore it is an accumulating problem you are facing?

DR. HUNT: Yes. And Dr. Jousse points out that there are a lot of children who are born with deformities which would have been fatal years ago and with modern treatment we are keeping them alive, and they have to be given some type of service, too.

COMMISSIONER FIRESTONE: In other words, the advances in medicine are increasing the problems that we are facing?

DR. HUNT: Yes.

COMMISSIONER FIRESTONE: That leads me to the second point which you deal with in paragraph 5 of your recommendations, in which you say that you

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Now, a lot of those cancers may be treatable or curable for a greater length of time, and there are people with cancer of the brain who may live for 5 or 6 years and with proper care, we have them up and about and at home.

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DR. HUNT: Yes.

COMMISSIONER LIEBERMAN: That leads me to the second point which you dealt with in paragraph 5 of your recommendations, in which you say that you

are in favour of a study to assess ways and means of improving medical leadership in rehabilitation in terms of increased general participation and increasing the number of specialists in Physical Medicine and Rehabilitation. Could you be a little bit more specific as to what you mean when you speak of medical leadership in this field?

DR. JOUSSE: I feel, sir, that it is inherent in my thinking that we must make, in the making of a doctor, in the education of the doctor, somewhere along the line we must make them feel a real concern for patients after an acute phase of illness or injury when they are discharged or ready for discharge from hospital, so that that concern can be translated into responsibility for that patient so that the care will carry him out into the society where he wishes to live and help him to circumvent or overcome whatever persisting disability may affect him.

COMMISSIONER FIRESTONE: Is this medical leadership which you describe confined to the period of training and education, or is this a continuing process? What kind of medical leadership would you expect from the profession in your specialist group after their training period?

DR. JOUSSE: It is a continuing - it is part of the continuing education of a doctor and I think the sooner we can make it apparent to the medical student, the house surgeon, the house physician or the young graduate in practice, that it is his responsibility, the more care will be forthcoming from the medical

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profession for this particular aspect of patients' needs.

Some people will perceive this need early and some later, and I suppose some, never, but with good teaching I think we can bring it ahead.

COMMISSIONER FIRESTONE: Is there anything that the Federal Government can do to encourage new leadership in this field, or should it be left entirely to the profession?

DR. HUNT: We have mentioned in the brief the fact that the Americans have used their Office of Vocational Rehabilitation in providing increased grants to medical schools to push this along. So often that is a very difficult field to persuade university authorities.

I know, in our own situation, our Dean had his work cut out to even establish our department. It is a job of educating the university faculties, not just the medical faculty, but the whole university, and all universities are looking for assistance, particularly in the departments where so much is training and so on.

COMMISSIONER FIRESTONE: Do you feel if there is so much earmarked for this specialty it would encourage what you recommend as desirable?

DR. HUNT: Yes, it would assist.

COMMISSIONER FIRESTONE: And you would recommend that the Federal Government should grant such assistance?

DR. HUNT: Yes, very much.

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DR. CRAWFORD: If I can expand that a little further, the physiatrist can't do it entirely by himself, but with the need for more - of course, we need many more members of the team, we need many more speech therapists, social counsellors, social workers, the people to assist in placing, and I don't necessarily mean the national employment service but people who can work in the hospital to assist in placing, and, of course, to get these people trained we need to expand all the aspects in the field, social service, the tremendous demand that has increased.

These schools of teaching have to be expanded, and I think the Federal Government - I would like that the Federal Government assist in financing to these schools so they can expand, have more teachers and take in more students.

COMMISSIONER FIRESTONE: I take it from what you say you have in mind a somewhat broader and more integrated program?

DR. CRAWFORD: I would like to say that I have a good integrated program in my own hospital, but I don't because I don't have enough of all the extra services. I cannot complete a program in my own hospital, I cannot get all the extra services.

DR. HUNT: These are the gaps which we mention.

COMMISSIONER FIRESTONE: And you feel that programs should be planned and created and improve such facilities; is that what you had in mind?

DR. HUNT: Yes, sir.

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THE CHAIRMAN: Thank you very much, Dr. Hunt, Dr. Lawson, gentlemen. It has been a very profitable discussion, and we are indebted to you for the brief you have presented to us.

DR. LAWSON: I would like to thank the Commission for allowing us to present our brief. It has been very enjoyable.

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THE CHAIRMAN: Thank you very much, Dr. Hunt, Dr. Dawson, gentlemen. It has been a very profitable discussion, and we are indebted to you for the help you have preserved to us.

[illegible]

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THE SECRETARY: Mr. Chairman, the next brief is that of Dr. Charles Okun and it will be known as exhibit number 313.

---EXHIBIT NO. 313: Submission of Dr. Charles Okun.

SUBMISSION OF

DR. CHARLES OKUN

APPEARANCES: Dr. Charles Okun
Mrs. Charles Okun
Dr. David Okun

THE CHAIRMAN: Dr. Okun, we are grateful to you for having accepted our invitation to go out of turn from what you had been placed originally on the list. This is a matter of obligement to us for which we are appreciative.

DR. OKUN: You are entirely welcome.

THE CHAIRMAN: If you would like to make your presentation. Will you introduce those who are with you?

DR. OKUN: I am Charles Okun and I have done considerable post graduate work subsequent to graduation here with hospitals, universities aside from years of general practice. On my right I have my dear wife Jeannette who has been working very closely with me and who has been a very large source of inspiration in my work.

With your permission I would like to read this brief which will not take too long and perhaps

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With your permission I would like to read this brief which will not take too long and perhaps

elucidate a little as I go along.

Will we ever know, how much damage has been, or is now caused by radiation? Only recently has the subject been brought out in the open and publicly discussed.

There is a great deal of evidence that X-Rays have caused serious injuries, and is inflicting and leaving its mark on our present and future generations.

Mechanical devices are available to-day which do control a major portion of these HAZARDS, without lessening, in fact, improving this miraculous diagnostic aid.

Such a NEW DEVICE is described by the author, who was personally seriously injured by X-Rays. This device has just recently been made available. It controls 90% and more of the emanation of X-Rays at the Dental X-Ray machine itself, and has been in use in his own practice successfully for some time.

I might mention this is a conservative figure,

Recommendations are made that:

(1) Compulsory registration and inspection be brought about for every X-Ray installation.

(2) More emphasis must be placed on PREVENTION, for the protection of ALL. OPERATOR, PATIENT and SURROUNDING PERSONNEL.

(3) This 'NEW DEVICE', well tested and recommended by the authorities, must become part of every Dental installation.

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Who can ever know, how much damage has been, or is now caused by radiation? Only recently has the subject been brought out in the open and discussed openly.

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Recommendations are made that:

(1) Consultant registration and inspection be brought about for every X-Ray installation.

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The onus is on us, to do everything possible without delay to bring about education and compliance so that the HAZARDS be kept at a minimum, before more people are deformed and maimed.

1. Although I am a member, in good standing, and have had the co-operation and support of the Canadian Dental Association, Ontario Dental Association and the Royal College of Dental Surgeons, I am not appearing here in any official capacity, but only as a private citizen, interested in bringing to the attention of this Commission constructive material, as a result of years of research, study and personal experiences.

2. Early recognition and treatment of disease is important. My opinion though, is that not enough emphasis has been placed on the subject of PREVENTION. The old adage of "ONE OUNCE OF PREVENTION IS WORK A POUND OF CURE", still holds good. PREVENTION is the greatest valuable factor in the elimination of disease, reduction of the financial burden and the raising of the standard of the health of ALL the people.

3. It has been definitely established, and is common knowledge that, Radiation, can cause, has caused and is to-day inflicting,

(a) Carcinoma, Eye Cataracts,

(b) Damage to Skin, Lymphatics, Bone Marrow, and the Gonads,

(c) Sterility,

(d) Shortening of the life span,

(e) Genetic Harm,

(f) Death.

The crux is on us, to do everything possible without delay to bring about education and compliance so that the HAZARDS be lost at a minimum, before more people are affected and maimed.

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(a) Carcinoma, the Cancerous.

(b) Damage to Skin, Lymphatics, Bone Marrow, and the Gonads.

(c) Sterility.

(d) Shortening of the life span.

(e) [illegible]

(f) [illegible]

4. The public are becoming increasingly aware of the true dangers of Radiation. Minimizing the HAZARDS is not the solution. The only rational approach is the utilization of all practical precautionary means. This will remove the existing public resistance to X-Rays.

As an estimate, there are in Canada approximately 20 million x-rays taken annually of which 15 million are dental x-rays.

5. Radiation effects are generally not immediately seen, the latent period has been known to be as high as twenty-five years. Radiation is accumulative and its effects are irreversible. Deplorable is the fact that more deformities and sterility is evident today, especially to present and former X-Ray technicians, a large number of young females are to-day employed as X-Ray technicians.

6. In this day of atomic fission, nuclear blasts, greater use of isotopes, use of atomic energy for peaceful means, increased use of radiation for diagnostic and therapeutic purposes, more attention must be placed on keeping the HAZARDS down to a minimum. Let me make myself clear. I am fully aware of the advantages of X-Rays. I heartily recommend their use as a valuable and miraculour diagnostic and therapeutic aid. I am not recommending less Radiation used, perhaps more, but <u>only</u> when <u>all practical precautions are taken</u>.

7. Unfortunately, I along with hundreds of others, have suffered from Radiation injury, to the point where I have had considerable plastic surgery performed, and was unable to practice my

[illegible] The public is becoming increasingly aware of the dangers of radiation. Minimizing the dangers is not the solution. The only rational approach is the elimination of all unnecessary exposure. We will never [illegible] the existing public ignorance to [illegible]

[illegible] estimate, there are in Canada approximately [illegible] from x-rays taken annually of which [illegible]

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profession for a long period. I with the help of my dear wife, without whose inspiration and her close work with me, would not have made it possible, have for years dedicated ourselves to the education of the professions to the HAZARDS, and to the compliance of taking the practical precautions, that are to-day available, so that others shall not suffer as I.

8. I have for several years, written and had published articles, and on invitation and repeated requests, had and still have, the honour and privilege of giving clinics on this vital subject, to professional groups, in Canada, United States and Mexico.

9. I have worked closely with the Canadian Dental Association, American Dental Association, Radiologists, Universities, Federal and Provincial Health Authorities, Princess Margaret Hospital, Royal College of Dental Surgeons, etc., and have received excellent concurrence.

10. I would like to quote from a letter I received from the Hon. Mr. Monteith, our Minister of Health, quote "I am sure that radiologists, their associations and all who are concerned with radiation protection work agree with your observations respecting the control of this type of equipment".

11. Also a quote from Handbook #50 published by U.S. National Bureau of Standards, who have done years of work on this subject, pp. 3, "It is not known that the body can tolerate any radiation".

12. Appropos a quote from the book

professional for a long period. I with the help of my dear wife, without whose inspiration and her close work with me, would not have made it possible, have for years gladly and cheerfully to the education of the professions to its benefit, and to the compliance of taking the practical precautions, that are to-day available, so that others shall not suffer as I.

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12. Compose a quote from the book

"Radiation, What it is and How it effects you", which I recommend for your reading, by Jack Schubert and Ralph E. Lapp, published by Wm. Heinemann Ltd., pp. 11, quote "There is not the slightest shred of evidence that radiation has any beneficial effects for a normal person. Even a small amount of radiation may be dangerous -- such is the case for women in very early pregnancy".

THE CHAIRMAN: Dr. Okun, if I may interject. You have on pages four and five pretty well devoted to quotations from various authors in support of your basic proposition of the danger of radiation which I think we accept without reservation.

DR. OKUN: The only factor, though, I question whether at this point whether we should enlighten the public.

THE CHAIRMAN: That is quite true but this brief is a public one.

DR. OKUN: It should not take too long to read that.

THE CHAIRMAN: I would suggest you eliminate the quotations and perhaps leave yourself a little more time for discussion.

DR. OKUN: I might say this in a report it is stated in an article in the Welfare Bulletin about 100 radiologists have died.

THE CHAIRMAN: You have them all tabulated here.

DR. OKUN: In other words, you would rather I leave out -- I may add something that is not

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in there. According to the best conservative estimates this is Professor Mueller and he says:

"The present population of the United "States will pass on 16 million new "mutations to the next generation of "100 million children."

Also as an addition, if I may, there is a report on 933 cases treated during 1946 to 1953. Also there is some as the result of accidents, injuries as the result of fluoroscoping.

And now, I would like to quote from a handbook of the National Bureau of Standards where they mention that dental rooms containing x-ray machines shall be provided with primary protective barrier at sides behind the chair and in the floor and ceiling.

There is a question of some of the twenty in that -- would you like me to read that?

THE CHAIRMAN: Well, I have made a suggestion but you do as you like. I am just telling you you do not have to convince us that today is Thursday.

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"The present population of the United

"States will pass on 6 million new

"population to the next generation of

"100 million children."

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I was instrumental in having the Royal College of Dental Surgeons who are most cooperative, send out with the assistance of the Professor of Radiology, Faculty of Dentistry, University of Toronto, to every practising Dentist in Ontario, a list of recommendations, along the lines I proposed.

I respectfully submit the following recommendations:

(a) No Dental X-Ray machine should be allowed to operate without the "X-RAY SAFE", which has provision for a filter and columinator at the machine end, and restricts the spread of damaging and useless rays.

(b) All new dental X-Ray machines are to have the "X-RAY SAFE" as a component part thereof.

(c) As passed by resolution at the 25th Annual Convention of the Canadian Association of Radiologists, Compulsory Registration and Inspection should be established of every X-Ray installation. Financed by nominal registration fee and assistance from the Federal and Provincial Governments. Many States in the United States have for years had legislation and inspection on this matter. I fail to understand why Canada has not moved faster. A great deal of furor, and rightly so, has been raised about fallout. It has been estimated that there is about twenty times the natural fallout generated in professional diagnostic offices. Up to 90% of this can be controlled without loss of diagnostic value.

THE CHAIRMAN: Go right ahead. We want you to devote your time to the recommendations and so

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(c) As agreed by resolution at the 45th annual Convention of the Canadian Association of Radiologists, compulsory registration and inspection should be established of every X-Ray installation. Financed by nominal registration fee and assistance from the General and Provincial Governments. Many States in the United States have for years had legislation and inspection on this matter. I fail to understand why Canada has not moved faster. A great deal of fumes, and rightly so, has been raised about nothing. It has been estimated that there is about twenty times the natural fallout generated in professional diagnostic services. Do these and the contrast dye without I as of dangerous x-ray.

THE CHAIRMAN: To Dr. [illegible]

want you to devote your time to the recommendations and

forth. We accept your basic premise.

DR. OKUN: I submit that to expedite this it would certainly cost all the people of Canada less, perhaps only ten cents per person, and would protect all the people, by having as an alternative plan, for the people through the Government to supply this device for all existing Dental installations. Consider the lower medical and hospitalization costs which would result. Compare this to the millions now spent on treatment and research. Yet the number of cases of cancer treated is not decreasing, but increasing. Is not the removal of causes or PREVENTION more important?

There are certain statements here which are references. I will go on.

We have for years put forth a great deal of personal effort and personal heavy expenditures, to bring this vital problem out in the open, unfortunately there is only so much one can personally do. This is a matter for the good of all the people, and should be handled by a department of the Government, with it's machinery.

Although I have had more experience in the Dental field, I am interested in protection against radiation in all fields, Medical, Chiropractic, Industrial, et.

In view of the fact that;

(a) Health under the British North America Act is a provincial matter,

(b) In most provinces there are already departments set up for this purpose, with trained personnel, physicists, etc.,

forth. We cannot work here in vain.

[illegible] I submit that to eradicate this it would cost less, and all the people of Canada less, perhaps only ten cents per person, and would protect all the people, by having as an alternative plan, for the people through the Government to supply this device for all existing dental institutions. Consider the lower medical and hospitalization costs which would result. Compare this to the millions now spent on treatment and research. Yet the number of cases of cancer treated is not decreasing, but increasing. Is not the removal of causes of [illegible] more important?

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In view of the fact that:

(1) In most provinces there are already departments set up for this purpose, with trained personnel [illegible]

(c) Many States in the United States are handling this as a State matter,

(d) Various groups are using Radiation,

I feel that any action should be at the Provincial level with the cooperation of the Federal Government.

At every clinic I have given, at least a dozen individuals have drawn my attention to their X-Ray injuries, including loss of limb, growing blindness, etc. We must remember that this is only a mirror as to what is taking place inside the body.

Scientific tests have been made, and reported in the literature, on several occasions, that the face dose received from the use of dental machines, using the plastic cone alone, which permits a fan of X-Rays, as it is not a protective device, only a pointer, for each dental film is 5 Roentgen units average, or 5000 Milli-Roentgen units. For a full mouth X-Ray diagnosis, of say 16 dental films, the face dose on the average is 80 Roentgen units, or 80,000 Milli-Roentgen units. One must also remember that any registrations reported, must of necessity be only point or very small area registrations, and do not, give the toal amount of radiation generated, nor the amount of the entire body or tissue irradicated.

When one weighs the above against the Maximum Permissible Doses recommended by the authorities, namely 100 Milli-Roentgen units per week for the operator, and one tenth of this amount for the public, one will understand why I am deeply concerned. That is why I am recommending the use of the "X-Ray Safe", which controls

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When one weighs the above against the Maximum Permissible Doses recommended by the authorities, namely 100 Milli-Roentgen units per week for the operator, an, one tenth of this amount for the public, one will understand why I am deeply concerned. That is why I am recommending the use of the "X-Ray Card", which controls

90% and more of the emanation, right at the machine, and confines the rays.

I trust that I have submitted enough evidence, to convince this Honourable Commission, that there is NO SAFE THRESHOLD KNOWN. Radiation can cause, has caused, is causing today, and will continue to cause and inflict injuries on our people unless immediate steps are taken to use the practical precautions available, and keep the HAZARDS down to a minimum, BEFORE more of our population present and future are deformed and maimed. The use of the "X-RAY SAFE" in the opinion of leaders in the X-Ray field is the safest approach to this problem. At once without any further delay.

Of course, any action taken is best processed with the cooperation and supervision of the professions involved, and the use of the existing machinery.

All of which is respectfully submitted.

THE CHAIRMAN: Thank you very much, Dr. Okun. I wouldn't want you to get any idea that we are not happy to hear from you. We are. Just by way of illustration we had an irresponsible person here yesterday afternoon interrupting the proceedings with the objection that individuals were not welcome. Your attendance here this morning is the answer to that kind of nonsense. Your being here with a matter that is as important as the question of radiation makes us say thanks to you for having taken the time as an individual in the preparation of this submission and for your attendance here.

DR. OKUN: I was wondering, with your permission Mrs. Okun would like to make a few remarks..

205 and more of the examination, right at the machine, and continues the rays.

I trust that I have submitted enough evidence, to convince this Honourable Commission, that [illegible] has caused, is causing today, and will continue to cause and inflict injury on our people unless immediate steps are taken to use the protectional precautions available, and keep the [illegible] down to a minimum. MEDICAL men of our population present and future are concerned and anxious, the use of the "X-RAY BEAM" in the solution of leaders in the X-Ray field is the safest approach to this problem. [illegible]

Of course, any action taken is best processed with the cooperation and supervision of the professions involved, and the use of the existing machinery [illegible] All of which is respectfully submitted.

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[illegible] Dr. [illegible] would like to make a few remarks.

MRS. OKUN: Mr. Chairman and Members of the Royal Commission, I wold like the privilege of adding a request of the Royal Commission Members, that could result in many benefits to Humanity, which face our populations today, and which Dr. Okun and I have been concerned these many years.

Working with Dr. Okun during his presentations of Essay and Table Clinics, here in Toronto, in Chicago at the Chicago Dental Convention, I found it unbelievable that the Professions were unaware of the hazards they were working with in their X-Ray procedure. The X-Ray technicians became greatly concerned, particularly the nurses and young women trained as assistants, that very little prevention was provided for users of X-Ray machines. To help eliminate much of this danger, Dr. Okun presented the professions recommendations and became determined to provide safety at the machine itself. Himself a radiation sufferer twice.

We might well note the X-Ray crisis since William Konrad Roentgen inveted X-Ray in 1895. And the year later when Thomas A Edison invented the Fluoroscope and then the wonders by the late famed Dr. Emil Grubbe who had parts of his body amputated piecemeal for X-Ray use. He himself was harmed.

The greatest historical background of our inventors in the last 50 years have been the announcement of the thousands of injuries and deaths that resulted from these diagnostic miracles. Namely, the X-Ray machine. That emits harmful Rays despite the utmost care.

Mr. Chairman, Mr. Chairman and Members of the Royal Commission, I would like the privilege of adding a request of the Royal Commission members, that could result in very benefits to humanity, which face our populations today, and which Dr. Ohms and I have been concerned these many years.

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We might well note the X-Ray crisis since William Conrad Roentgen invented X-Ray in 1895. And the year later when Thomas A Edison invented the fluoroscope and then the nurses by the late famed Dr. Emil Grubbe who had parts of his body amputated because of X-Ray use, "Radiosis" was named.

The greatest historical bac-ground of our inventions in the last 50 years have been the immediment of the thousands of injuries and deaths that resulted from these diagnostic miracles. Really, the X-Ray machine, that small machine I was despite the utmost

We must accept the statement that no cell fully recovers from a dose of Radiation. Therefore, we must have a safe machine. With Prevention and Education we can and hope to eliminate much of the diseases that are with us today and increasing such as Cancer, and increasing deformities and Sterility in future generations, by enlightenment as to the prevention at the machine itself.

And X-Ray has definitely been established as causing untold harm.

When we must note that in the United States there are some 2,500 Institutions using Radioisotopes and 900 Clinics and Hospitals, we must assess from this figure what we are dealing with.

Particularly in Schools, Institutions and Hospitals where our youth is in training , our first duty to them is to protect them from radiation harm. Where children undergo routine X-Ray examination, and in schools where children pass through as guests, as I have seen in some schools, it should be our desire and duty, to protect them from future harmful radiation effects.

Dr. Okun has perfected such a device. There is today little need to expose patient or operator to more than is necessary in the taking of an X-Ray film.

It has been established that X-Rays travel and no one even at a distance is safe, therefore, we must strive for Safety through Prevention, and enlighten the young as to the dangers and use of X-Ray.

This Prevention we are presenting to the Commission, as a means of safeguarding the people,

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This Prevention we are presenting to the Commission, as a means of safeguarding the people,

has been invented, and made by Dr. Okun, and tested on a life-like Phantom, with the cooperation of the Princess Margaret Hospital.

It has been our pleasure to be able to serve Humanity, cost in time and money were forgotten in the hope to be able to present this to the Professions concerne and the cooperation of the professions in his chosen scientific endeavour has enabled him succeed with a safety hitherto unknown.

Too numerous to mention are the cases where lay people as well as professions disclosed harm to us such as a letter we received from a 35 year old dentist in New York whose Oculist informed him he was losing his eyesight as a result of X-Ray.

Neither Welfare Aid or Hospital Care can compensate the person stricken with disease that radiation caused, that preventive measures could have avoided.

If we are to heed the publicized scientific statement of Dr. Herbert Muller, Nobel Prize Winner, "That the present population of the U.S. will pass on 16,000,000 new mutations to the next generation, of 100,000,000 children.

We will have forfeited one of the greatest advances in Medical Science and to keep it is up to the few in whose hands lay the destiny of our nation, namely our children, by the people who minister to the upkeep of our Schools, our Hospitals and Institutions to provide to our teachers and users. Today we have the safety measures at our command.

COMMISSIONER STRACHAN: Mr. Chairman, I am sure Dr. and Mrs. Okun have laid the facts plainly

Ohlson - 1119

has been invented, and made by Dr. Ohlson, and tested on a life-like phantom, with the cooperation of the Princess Margaret Hospital.

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MR. CHAIRMAN: Mr. Chairman, I am sure Dr. and Mrs. Ohlson have left the facts plainly

before us so that no questions will be necessary. I would only like to ask if your device is applicable to all X-ray machines as well as dental machines?

DR. OKUN: Well, frankly, I have not gone too much in that. There is no question about it, in medicine as you know they generally take in a larger area and as a result they have to put the head quite a piece away from the patient, but the idea of coning has been established even in medicine. I would like to see more coning and a columination used in all branches of science and industry. There is a field for all.

COMMISSIONER STRACHAN: Is the device available and in general use in dental circles?

DR. OKUN: As far as we have gone on this the Westinghouse Company have undertaken the manufacture of it. The Ash Temple Company are in the process of taking orders for it for reasonable future delivery, 60-day delivery. It has just recently got to that point.

COMMISSIONER STRACHAN: When you study all the effects of radiation, I am speaking particulary of the dental office, is it your experience or feeling that much of this has come about through misuse rather than use, proper use?

believe is so that no questions will be necessary. I would only like to ask if your device is applicable to all x-ray machines in general as dental machines?

DR. OKUN: Well, Frank, I have not gone too much in that. There is no question about it, in most cases as you know they generally take a larger size and as a result they have to put the hand quite a piece away from the patient, but the idea of coming has been established even in medicine. I would like to see more comfort and a convenience used in all branches of science and industry. There is a field for all.

CHAIRMAN STRAUSS: Is the service available and in general use in dental clinics?

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COMMISSIONER STRAUSS: When you study all the effects of radiation, I am speaking particularly of the dental office, is it your experience or feeling that much of this has to do about through misuse rather than use, proper use?

DR. OKUN: Well, the whole question boils down to this, that a great deal can be done to improve the equipment and techniques that are being used. There is certainly a great deal of room for important improvement.

COMMISSIONER STRACHAN: But do you feel that all the personal precautions have been taken by the individuals who have suffered?

DR. OKUN: Well, I may answer to you from my own experience. I feel that I took more than average precautions, and I still suffered as a result.

You have got to be practical, but, no, I wouldn't answer that it is a question of entirely mis-use. A lot of it was the fact of not having the knowledge and the facilities at that particular time.

COMMISSIONER STRACHAN: Do you consider the test film or disc available from Ottawa as reliable and efficient?

DR. OKUN: I would submit that that is a help. It is a help.

COMMISSIONER STRACHAN: Would you also say that the use of lead screens and aprons are of value?

DR. OKUN: They are a decided help. I remember now what I meant to incorporate. I meant to incorporate this, if I may, which I left out:

"The Maximum Permissible Dose, set by the International Commission on Radiological Protection is being repeatedly drastically reduced

DR. OKUN: Well, the whole question boils down to this, that a great deal can be done to improve the equipment and techniques that are being used. There is certainly a great deal of room for important improvement.

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periodically, from 200 milli-roentgen units per day in 1925 to 100 milli-roentgen units per week, in Feb. 1957. (Handbook #60, U.S. National Bureau of Standards). A 300% reduction was made from Dec. 1955 to Feb. 1957 in slightly over a year."

I feel there is no question in my mind there is a lot that we can learn about it, but just to give you an idea, here is a report that was in the Canadian National Health and Welfare published in April reporting the United States Scientific Committee on the Effects of Radiation. Even the smallest amount of radiation is liable to cause generic deleterious effects.

So, perhaps to answer that in our present knowledge in any device they have to check the amount of radiation is certainly a help. A great deal of interest has been aroused by the work of the federal department, and I feel that we are responsible for creating quite a lot of interest. The boys are taking more precautions than they did but I feel there is a great deal of room for improvement, and one of the reasons that I am appearing before the Commission is that I feel that is a slow, long, costly process to leave it as is and I would like to see, for the benefit of the general public as well as the operator and his assistants, people in adjoining rooms, if we could do something to expedite this whole matter.

THE CHAIRMAN: I take it this is a

[illegible] on reality, from 270 mill-rem/man
[illegible] per day in 1925 to 130 mill-
[illegible]
(Hardtack) 55, U.S. National Weapon
[illegible] of Standards). A 33% reduction was
made from Dec. 1 55 to Feb. 1957 in
slightly over a year."

I feel there is no question in my mind
there is a lot that we can learn about it, but just to
give you an idea, here is a report that was in the
Canadian National Health and Welfare published in
April reporting the United States Scientific Committee
on the Effects of Radiation. Even the smallest amount
of radiation is liable to cause genetic deterioration
effects.

So, perhaps to answer that in our
present knowledge in any service they have to choose
the amount of radiation is certainly a help. A great
deal of interest has been aroused by the work of the
federal department, and I feel that we are responsible
for creating quite a lot of interest. The boys are
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learn it as it is and I would like to see, for the benefit
of the general public as well as the operators and his
assistants, people in controlling rooms, if we could do
something to expedite this whole matter.

Mr. MACDONALD: I take in this to a

device which has been patented, and is now being manufactured by Westinghouse under licence, and will go on the market to be sold to the dental profession and others?

DR. OKUN: Yes.

THE CHAIRMAN: Thank you very much again, Dr. Okun.

DR. OKUN: Thank you, gentlemen, and Miss Girard, and I hope that we have done some good to expedite this whole matter, and my main point at issue in coming here is to try, not only in this field, but to try, if it needs some pressing, that more emphasis should be placed on prevention, rather than waiting till the disease is caused and costs the people and the Government so much more and so much suffering.

Why there is an apathy of society to preventive measures I don't know. Perhaps sociologists may be able to explain it, but a great deal of thought, I feel, should be done on that phase, and anything we can do to educate those in control, as well as the public, to take precautionary measures, I think is very constructive.

THE CHAIRMAN: Well, we are grateful to you for the approach to the problem, not as one of carping criticism and so forth and etcetera, and blaming everybody, but coming forward with a proposal to remedy the situation.

DR. OKUN: Yes, we must face facts. Thank you.

--- Luncheon Adjournment.

device which has been patented, and is now being manufactured by Westinghouse under license, and will go on the market to be sold to the dental profession and others.

DR. [illegible]: Yes.

THE CHAIRMAN: Thank you very much again, Dr. [illegible].

DR. [illegible]: Thank you, gentlemen, and Miss Conway, and I hope that we have done some good to expedite this whole matter, and my main point at issue in coming here is to try, not only in this field, but to try, if it needs some pressure, that more emphasis should be placed on prevention, rather than waiting till the disease is issued and costs the people and the Government so much more and so much suffering.

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THE CHAIRMAN: Well, we are grateful to you for the approach to the problem, not as one of carping critiques are so [illegible], and blaming everybody, but coming forward with a proposal to remedy the situation.

MR. [illegible]: Yes, we must face facts.

--- [illegible] adjournment.

---On resuming at 2:00 p.m.

THE SECRETARY: Mr. Chairman, the next submission is the Canadian Conference on Physiotherapy, to be known as exhibit 314, and Dr. Botterell will speak to the brief and introduce his delegation.

---EXHIBIT NO. 314: Submission of the Canadian Conference on Physiotherapy.

SUBMISSION OF

THE CANADIAN CONFERENCE ON PHYSIOTHERAPY

APPEARANCES: Dr. E.H. Botterell
Miss Ruth Bradshaw
Miss Mary Martin
Mr. Edward Dunlop
Dr. A.T. Jousse

DR. BOTTERELL: I am E. H. Botterell, Chairman of the Continuing Committee of the Canadian Conference on Physiotherapy. The personnel of this Committee is listed in Appendix B. I am accompanied by Miss Ruth Bradshaw, Lecturer in Physical Therapy in the School of Physical and Occupational Therapy, University of Toronto, Miss Mary Martin, National Consultant on Physical Therapy of the Canadian Arthritis and Rheumatism Society, and Mr. Edward Dunlop, Executive Director of the Canadian and Rheumatism Society, and Dr. A. T. Jousse, Medical Director of Lyndhurst Lodge.

The introductory section (paras. 1 to 6) explains that The Canadian Conference on Physiotherapy

---In resuming at 2:10 p.m.

---EXHIBIT No. 114: Submission of the Canadian Conference on Physiotherapy.

SUBMISSION OF

THE CANADIAN CONFERENCE ON PHYSIOTHERAPY

APPEARANCES: Dr. E.H. Bottrell

Miss Mary Martin
Mr. Edward Dunlop
Mr. A.T. Jones

DR. BOTTRELL: I am E. H. Bottrell, Chairman of the Continuing Committee of the Canadian Conference on Physiotherapy. The personnel of this Committee is listed in Appendix B. I am accompanied by Miss Ruth Bradshaw, Lecturer in Physical Therapy in the School of Physical and Occupational Therapy, University of Toronto, Miss Mary Martin, National Consultant on Physical Therapy of the Canadian Arthritis and Rheumatism Society, and Mr. Edward Dunlop, Executive Director of the Canadian and Rheumatism Society and Mr. A. T. Jones, Medical Director of Lynwood Lodge.

The introductory section (paras. 1 to 5) explains that The Canadian Conference on Physiotherapy

was held last year under the joint auspices of the Association of Canadian Medical Colleges, the Canadian Association of Physical Medicine and Rehabilitation and the Canadian Physiotherapy Association. The Conference appointed a Continuing Committee and the views and recommendations contained in this submission are those of the Continuing Committee.

Our submission has been divided into sections which parallel your terms of reference. The sections of our brief requiring the greatest attention are those which bear on the demand and need for physiotherapists and the existing and future deficiency of personnel. We believe that the situation described in this submission is sufficiently serious to demand a massive and urgent effort to correct it. Failing this, more than half of the people in Canada will continue to be denied the benefit of physiotherapy, and consequently may suffer needless disabilities. Let alone the humanitarian consideration involved, our economy can hardly sustain such waste.

Our findings and recommendations are based mainly upon conclusions drawn from the statistical surveys. One of hospitals of over 50 beds; the second survey of the 1,053 active members of the Canadian Physiotherapists Association. The results of these surveys are tabulated in Appendix A, Tables 1 to 12.

A Summary of Our Main Recommendations is contained in paragraphs 7 and 8 and with your permission, Mr. Chairman, I shall read them.

"The Committee's main recommendations

was held last year under the joint auspices of the Association of Canadian Medical Colleges, the Canadian Association of Physical Medicine and Rehabilitation and the Canadian Physiotherapy Association. The Conference appointed a Continuing Committee and the views and recommendations contained in this submission are those of the Continuing Committee.

Our submission has been divided into sections which parallel your terms of reference. The sections of our brief requiring the greatest attention are those which bear on the demand and need for physiotherapists and the existing and future deficiency of personnel. We believe that the situation described in this submission is sufficiently serious to demand a massive and urgent effort to correct it. Failing this, more than half of the people in Canada will continue to be denied the benefit of physiotherapy, and consequently may suffer needless disabilities. Let alone the humanitarian consideration involved, our economy can hardly sustain such waste.

Our findings and recommendations are based mainly upon conclusions drawn from the statistical surveys, one of hospitals of over 50 beds; the second surveys of the 1,082 active members of the Canadian Physiotherapists Association. The results of these surveys are tabulated in Appendix A, Tables 1 to 12.

A Summary of our Main Recommendations is contained in paragraphs 7 and 8 and with your permission, Mr. Chairman, I shall read them.

"The Committee's main recommendations

are entirely concerned with the education of sufficient numbers of physiotherapists, and may be summarized as follows:

(I) That the facilities for training physiotherapists in Canada be more than doubled by an increase from 6 to 15 in the number of schools of physiotherapy in Canada, at the rate of one new school each year from 1963 to 1971 (see paragraph 44) and at estimated annual rates of expenditure of $1,095,500 in the period 1963 to 1970 rising to $1,888,480 in the period 1971 to 1980 (see paragraphs 48 to 53).

(11) That multi-stage education for physiotherapists be introduced, whereby the therapist receives diplomate training and after an appropriate period in practice, may return for futher training leading to a degree (see paragraphs 33 to 38).

"The Committee makes additional but subsidiary recommendations with respect to more efficient use of personnel, improved prescription direction and supervision of physiotherapy, use of auxiliary personnel and the inclusion of physiotherapy among extended health benefits (see paragraphs 10 to 14)."

These main recommendations will be discussed, as well as our subsidiary recommendations, as they occur under the various terms of reference.

With respect to Term of Reference A "Existing Facilities and Methods for the Provision of

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(i) That the facilities for training physiotherapists in Canada be more than doubled by an increase from 6 to 15 in the number of schools of physiotherapy in Canada, at the rate of one new school each year from 1953 to 1971 (see paragraph 44) and at estimated annual rates of expenditure of $1,095,500 in the period 1964 to 1970 rising to $1,386,44[illegible] in the period 1971 to 1980 (see paragraphs 46 to 53).

(ii) That multi stage education for physiotherapists be introduced, whereby the therapist receives diplomate training and after an appropriate period in practice, may return for further training leading to a degree (see paragraphs 2[illegible] to 39).

The Committee makes additional but subsidiary recommendations with respect to more efficient use of personnel, improved prescription direction and supervision of physiotherapy, use of auxiliary personnel and the inclusion of physiotherapy among extended health benefits (see paragraphs 10 to 14)."

These and other recommendations will be discussed, as well as our subsidiary recommendations, as they occur under the various terms of reference.

With respect to Term of Reference A "Existing facilities and methods for the provision of

Personal Health Services", we have nothing to add. This subject has been dealt with briefly in our submission and at length in the submission made by the Canadian Physiotherapy Association.

Under Term of Reference B "Methods for Improving Existing Health Services" (page 5 of our submission) we advise that the primary methods are the provision of sufficient numbers of well trained personnel, and adequate physical facilities. We deal with these primary requirements in later sections of our submission.

In the remainder of this section of our submission we discuss our subsidiary recommendations.

1. <u>More efficient use of trained personnel</u> - Professional physiotherapists should be relieved of clerical and housekeeping duties, a matter for attention by hospital administrators.

2. <u>Improved prescription and direction by doctors of physiotherapy</u> - Physiatrists should be placed in charge of large departments. Senior undergraduate and graduate medical students should be provided greater opportunities to observe the contribution which physiotherapy can make to the treatment of patients. This is a problem largely to be tackled by authorities of medical education.

3. <u>Use of auxiliary personnel</u> - The use of nursing aides and assistants has been important in meeting needs once met only by professional nurses. The practice of Physiotherapy does not contain as many purely domestic and housekeeping elements as nursing used

Personal Health Services", we have nothing to add. This subject has been dealt with briefly in our submission and at length in the submission made by the Canadian Physiotherapy Association.

Under Item of Reference B "Methods for Improving Existing Health Services" (page 5 of our submission) we advise that the primary methods are the provision of sufficient numbers of well trained personnel, and adequate physical facilities. We deal with these primary requirements in later sections of our submission.

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2. Improved supervision and direction by doctors of physiotherapy - Physiatrists should be placed in charge of large departments. Senior undergraduate and graduate medical students should be provided greater opportunities to observe the contribution which physiotherapy can make to the treatment of patients. This is a problem largely to be tackled by authorities of medical education.

3. Use of auxiliary personnel - The use of nursing aides and assistants has been important in freeing nurses from not only by professional nurses. The practice of Physiotherapy does not contain as many purely domestic and housekeeping elements as nursing used

to contain. For this reason, one cannot expect the use of aides and assistants to make the same quantitive contribution which this scheme has made in nursing. On the other hand, we believe that some treatments and treatment procedures in physiotherapy can be carried out by supervised assistants under proper control, and we recommend that the Canadian Physiotherapy Association should consider production of a guide to in-service training of such auxiliaries.

4. Physiotherapy as an insured benefit - As a matter of principle, we believe that physiotherapy should be included among the extended health benefits in any approved health care insurance scheme. We recognize that for many years to come, there will be difficulty in providing physiotherapy to all those who need it in all circumstances.

Term of Reference C is concerned with the correlation of new or improved programs with existing services. Physiotherapy is fundamentally ancillary to the practice of medicine and to the operation of hospitals and rehabilitation centres. We believe, therefore, that any rational system for the correlation of medical practice, hospitals and rehabilitation centres will automatically provide for the national correlation of physiotherapy services.

Our most important findings, Mr. Chairman, are these set forth in Term of Reference D "Future Requirements for Personnel to Provide Health Serives". (Page 7)

The current situation is described in

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As a matter of principle, we believe that physiotherapy should be included among the extended health benefits in any approved health care insurance scheme. We recognize that for many years to come, there will be difficulty in providing physiotherapy to all those who need it in all circumstances.

Item of Reference C is concerned with the consideration of new or improved programs with existing services. Physiotherapy is fundamentally ancillary to the practice of medicine and to the operation of hospitals and rehabilitation centres. We believe, therefore, that an rational system for the coordination of medical practice, hospitals and rehabilitation centres will automatically provide for the national co-ordination of physiotherapy services.

Our most important findings, Mr. Chairman, are these set forth in Term of Reference D "Future Manpower for Personnel to Provide Health Services". (Page 7)

The current situation is described in

paragraphs 17 and 18. From the survey of hospitals, 50 beds or larger, it was learned that the responding institutions employ 930 physiotherapists, and that there are now 542 vacancies.

The situation which we are likely to face in 1970 is described in paragraphs 19 to 21. By that year it is estimated that a minimum of 2,774 physiotherapists will be required. If the existing schools of physiotherapy graduate students at the rate which they forecast, and allowance is made for the natural attrition rate, and for imports, there will be 2,335 practising physiotherapists in 1970, that is to say, 439 less than are required.

This estimate of the demand by 1960 is conservative, making little or no allowances for new developments. Such factors described in paragraph 24 indicate an estimated demand for 3,000 - 3,500 physiotherapist in 1970 which we judge would not be unrealistic. This means a deficiency of from 665 to 1165 physiotherapists.

In the United Kingdom there is 1 physiotherapist per 6,000 of population, a proportion judged to be insufficient by the authorities in that country. In Canada, there is 1 physiotherapist per 15,000 of population. Implementation of recommendations contained in this submission would produce a ratio of 1 physiotherapist per 8,300 of the Canadian population by 1970, and would achieve a ratio of 1 physiotherapist per 5,600 of the population by 1980.

The urgency of the situation may be

paragraphs 17 and 18, when the survey of hospitals, [illegible] was in force, it was agreed that the [illegible] institutions among the psychiatrists, and that there [illegible] for 52 vacancies.

The situation which we are likely to face in 1960 is very [illegible] from 1 to 2. By that year it is estimated that a minimum of 2,700 psychiatrists will be required. If the existing schools of psychiatry graduate students at the rate which they [illegible], and allowance is made for the normal attrition rate, and for imports, there will be 2,315 practising psychiatrists in 1970, that is to say, 475 less than are required.

The authors of the report by [illegible] are conservative, making little or no allowance for new developments. Such factors described in paragraph [illegible] indicate an estimated demand for 1,000 - 3,000 psychiatrists in 1970 which we judge would not be unrealistic. This means a deficiency of from 925 to [illegible]

In the United Kingdom there is 1 psychiatrist per 6,000 of population, a proportion judged to be just sufficient by the authorities in that country. In Canada there is 1 psychiatrist per 14,000 of population. Implementation of recommendations contained in this statement would provide a ratio of 1 psychiatrist per 8,000 of the Canadian population by 1970, and would achieve a ratio of 1 psychiatrist per 6,000 of the population by 1980.

The shortage of the existing [illegible]

well described by quoting paragraph 26 of the submission.

"Vigorous measures must be instituted "immediately to rectify the situation "if the benefits of physiotherapy are "to become generally available to the "sick and disabled, and if the "physiotherapy profession is to survive "the fracturing pressures resulting "from a continuing inability to meet "personnel requirements."

Our main recommendations, Mr. Chairman, come under Term of Reference B "Methods of Providing adequate personnel with the best possible training and qualifications for such services. (page 9)

In paragraphs 29 to 43 we have considered several factors affecting the attainment of this objective. These factors are:

1. Recruitment.
2. Cost and length of training.
3. The development of personnel with higher qualifications.
4. The required number of location of schools of physiotherapy.
5. The academic affiliation of schools.
6. Appropriate arrangements for clinical teaching.

Following careful consideration of all these factors our main recommendations were prepared. I should now like to quote paragraph 44, subsections (i) to (iv) of our brief which contains our main recommendations:

well described by quoting paragraph 13 of the submission.

"Vigorous measures must be instituted
"immediately to rectify the situation
"if the benefits of physiotherapy are
"to become generally available to the
"sick and injured, and if the
"physiotherapy profession is to survive
"the fracturing pressures resulting
"from a continuing inability to meet
"the sound requirements."

Our main recommendations, Mr. Chairman, come under Term of Reference B "Methods of providing adequate personnel with the best possible training and qualifications for such service." (page 3).

In paragraphs 23 to 40 we have considered several factors affecting the attainment of this objective. These factors are

1.

2. Cost and length of training.

3. The development of personnel with higher

4. The required number of location of schools of physiotherapy.

5. The academic affiliation of schools.

6. [illegible]

training.

Following careful consideration of all these factors our main recommendations were prepared. I should now like to quote paragraph 44, suggestions (i) to (iv) of our brief which contains our [illegible]

"The following recommendations are made:

(i) That there should be 15 schools of physiotherapy in Canada by 1971.

(a) Six schools now exist: University of British Columbia (Vancouver) University of Alberta (Edmonton), University of Manitoba (Winnipeg) University of Toronto (Toronto), University of Montreal (Montreal) and McGill University (Montreal).

(b) The seven universities with medical schools and without schools of physiotherapy should be encouraged to consider urgently the creation of such schools - University of Saskatchewan (Saskatoon), University of Western Ontario (London), Queen's University (Kingston), University of Ottawa (Ottawa,) University of Sherbrooke (Sherbrooke), Laval University (Quebec) and Dalhousie University (Halifax).

(c) Two additional universities not presently possessing faculties of medicine, should be encouraged to consider urgently the creation of schools of physiotherapy leading only to a diploma (see paragraph 36 (i) and 42). These should be located having regard to the facilities available and the density of population. The following universities might be considered: McMaster University (Hamilton), University of New Brunswick (Fredericton) and University of Alberta (Calgary Campus).

Montreal [illegible]

(a) That there should be 10 schools of physiotherapy in Canada by 19[illegible]

(b) The seven and sixteen with medical schools and without schools of physiotherapy should be encouraged to consider urgently the creation of such schools - University of Saskatchewan (Saskatoon), University of Western Ontario (London), Queen's University (Kingston), University of Ottawa (Ottawa), University of Sherbrooke (Sherbrooke), Laval University (Quebec) and [illegible]

(c) The additional universities now [illegible] possession faculties of medicine, should be encouraged to consider urgently the creation of schools of physiotherapy leading only to a diploma [illegible] (i) [illegible] [illegible] There should be [illegible] [illegible] available and the density of population. The following universities [illegible] (Hamilton), University of New Brunswick (Fredericton) and University of [illegible]

(11) That education for the physiotherapy profession be divided into two levels, one leading to a diploma, the other leading to a degree for diplomates after at least three years experience in the practice of their profession.

(111) That a system of bursaries be made available to encourage selected diplomates to take training leading to a degree.

(iv) That relationships between the hospital (and other institutional) physiotherapy departments training students and internes be placed on the same footing as are relations between faculties of medicine and the clinical departments of their affiliated teaching hospitals."

The results of implementing recommendation (i) (15 schools by 1971) in terms of the numbers of practising physiotherapists available from now until 1980 is shown in Estimate C - Table 11 of Appendix A.

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(ii) That education for the physiotherapy profession be divided into two levels, one leading to a diploma, the other leading to a degree for diplomates after at least three years experience in the practice of their profession.

(iii) That a system of bursaries be made available to encourage selected diplomates to take training leading to a degree.

(iv) That relationships between the hospital teaching students and interns be placed on the same footing as are relations between faculties of medicine and the clinical departments of their affiliated teaching hospitals."

The results of implementing recommendation (i) (in schools by 1971) in terms of the numbers of practising physiotherapists available from now until 1980 is shown in Estimate C - Table II of Appendix I.

PMcH/dpw

Turning now to Term of Reference F "Present physical facilities and future requirements for the provision of health services", our estimate here, unlike our estimate in other parts of the brief, is little more than an educated guess, for we made no special survey of physical facilities. We have not, however, found any informed persons who have had any quarrel with our estimate that existing facilities approximate 25% of the total predicted need in 1970.

Under Term of Reference G "Estimated Cost of Health Services now being rendered to Canadians with projected Costs of any New Programs Suggested" (paragraphs 46 and 47), we have not found it difficult to estimate the costs of services attributable to personnel. In 1962, these are about $4,800,000 per annum. In terms of 1962 dollars and salaries, these costs would rise to about $10,592,000 per annum by 1970. We have no way of estimating the other costs attributable to plant, maintenance and carrying charges.

Our major recommendations concerning the training of physiotherapists and the basis for the estimation of the costs of implementing these recommendations will be found in paragraphs 48 to 51. These estimated costs are summarized in paragraph 52:

Para. 52 "Summary of Training Cost Estimates"

From 1963 to 1970	C
To provide for 2,648 physiotherapists in practice by 1970, and the graduation of 2,828 diplomates	- $6,787,200
To train 353 "degree" students by 1970	- 847,200
c/f.	7,634,400

[illegible]

Then again, in Item 6 of Schedule 7 "Insert medical facilities and other requirements for the provision of health services", our estimate here, unlike our estimate in other parts of the budget, is little more than an educated guess, for we made no special survey of health facilities. We have not, however, found any in our on persons who have had any dealings with our estimate that existing facilities approximate 25% of the total predicted need in 1970.

Under Item of Reference C "Estimated cost of Health services now being rendered to Canadians with projected costs of any New Programs Suggested" (paragraphs 46 and 47), we have not found it difficult to estimate the costs of services attributable to newcomers. In 1967, these are about $4,800,000 per annum. In terms of 1967 dollars our salary as, these costs would rise to about $10,500,000 per annum by 1970. We have no way of estimating the other costs attributable to plant, maintenance and carrying charges.

Our major recommendations concerning the training of paramedicals and the basis for the estimation of the costs of rehabilitating these communications will be found in paragraphs 42 to 51. These estimated costs are summarized in paragraph 51:

Item 47 "Capacity of Existing Cost Facilities from 1963 to 1970"

To provide for 1,000 paramedicals in operations by 1970, and the expansion of 2,028 d [illegible] - [illegible]

To train the "Big Ones" students by 1970 - [illegible]

b/f.	$7,634,400
To provide bursaries for 353 "degree" students by 1970 -	1,129,600
	8,764,000
From 1971 to 1980	
To provide for 4,797 physiotherapists in practice by 1980, and the graduation of a further 6,093 diplomates -	14,623,200
To train 761 "degree" students by 1980 -	1,826,400
To provide bursaries for 761 "degree" students by 1980	2,435,200
	$18,884,800 (4)
TOTAL	$27,648,800

(4) Does not include provision of capital funds which may be required for the establishment or expansion of schools."

We have no comments to offer under Terms of Reference H.

Terms of Reference I, J and K deal with the important matters of finance, scientific development and priorities. We deal with these three topics in four paragraphs in our submission, paragraphs 55 to 58. I can be no more succinct than to quote these paragraphs as they stand.

Para. 55

"The Committee recognizes the complex constitutional problem inherent in any discussion of education. However, it is suggested that the Government

Lettered	1,114
b t.	37,624,400
To provide bursaries for 353 "degree" students by 1980	- 1,124,220
From 1971 to 1980	
To provide for 4,727 thyeiotherapists in practice by 1980, and the graduation of a further 6,663 diplomates	- 14,823,200
To train 701 "degree" students by 1980	- 1,328,400
To provide bursaries for 781 "degree" students by 1980	2,[illegible]
TOTAL	327,648,220

(4) Does not include provision of capital funds which may be required for the establishment or expansion of schools."

I have no comments to offer under Terms of Reference H

Terms of Reference I, J and K deal with the important matters of finance, scientific development and priorities. We deal with these topics in four paragraphs in our submission, paragraphs 55 to 58. I can be no more succinct than to quote these paragraphs as they stand.

Para. 55

"The Committee recognises the complex constitutional problem inherent in any discussion of education. However, it is suggested that the Government

of Canada should make conditional grants to the provinces to assist in the training of physiotherapists, shared on the same basis as costs are shared between the Government of Canada and the provinces under the Hospital Insurance and Diagnostic Services Act. In turn, the appropriate provincial health and hospital authorities would make it available to the universities the funds necessary to meet the net institutional costs of training. What is suggested here is not an intrusion into the field of education by the Government of Canada but rather a means to assist the provinces to ensure a supply of the personnel required for the effective operation of health programs jointly financed by the two levels of government."

Our comments about scientific development in relationship to physiotherapy are these:

Para. 56

"The attainment of higher degrees should be made possible for increasing numbers of physiotherapists. Graduate training is the seed-bed of teaching and scientific development."

Finally our views about priorities are these:

Para. 57

"It is held that, as the supply of physiotherapists more nearly approaches the demand, reasonable planning on the part of health and hospital authorities will ensure the most effective disposition of available personnel.

A. Priority must be given to teaching

of Canada should make additional grants to the provinces to assist in the training of physiotherapists, shared on the same basis as costs are shared between the Government of Canada and the provinces under the Hospital Insurance and Diagnostic Services Act. In turn, the appropriate provincial health and hospital authorities would make it available to the universities the funds necessary to meet the net institutional costs of training. What is urged here is not an intrusion into the field of education by the Government of Canada but rather a means to assist the provinces to ensure a supply of the personnel required for the effective operation of health programs jointly financed by the two levels of government."

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Finally our views about priorities are these:

para. 57

"It is held that, as the supply of physiotherapists more nearly approaches the demand, reasonable planning on the part of health and hospital authorities will ensure the most effective disposition of available personnel.

i. Priority must be given to teaching

hospitals or other institutions affiliated with faculties of medicine or other institutions which will provide for the teaching of physiotherapy internes, and at which other medical personnel are trained also.

B. A high priority should also be given to meeting the needs of institutions which have a high proportion of patients suffering from physical disabilities, such as convalescent hospitals, rehabilitation centres and chronic disease hospitals."

Para. 58

"Priority should be given to establishing facilities for the training of teachers in physiotherapy. It is understood that there are only 18 qualified teachers of physiotherapy practising in Canada. Schools of physiotherapy of the size of the new schools recommended in this submission each require 3 to 4 teachers."

Finally, Mr. Chairman, in paragraph 59 we have summed up our theses.

"The Committee has recommended a comprehensive program for the training of physiotherapists which requires educational facilities to be more than doubled within the decade and submits that these are moderate recommendations."

That concludes the presentation of the

hospitals or other institutions
, filled with facilities of
medicine or other institutions
which will provide for the
teaching of physiotherapy interests,
and it with other medical personnel
are trained also.

A fifth priority should also be
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tutions which have a high proportion
of patients suffering from physical
disabilities, such as convalescent
hospitals, rehabilitation centres
and chronic disease hospitals."

Page 38

"Priority should be given to establi-
shing facilities for the training of technicians in physio-
therapy. It is understood that there are only 16
[illegible]
Canada. Schools of physiotherapy - the size of the
new schools recommended in this submission each requires
3 to 4 teachers."

"Finally, Mr. Chairman, in paragraph
5 we have summed up our views.

"The Committee has recommended a
comprehensive program for the training of physiotherapists
which will provide educational facilities to meet
that qualified [illegible] people are available at these
[illegible]

That necessitates the [illegible] tion of the

summary of our submission. Mr. Chairman, we should be happy to answer any questions you and your colleagues may wish to put.

THE CHAIRMAN: Thank you very much, Dr. Botterell.

COMMISSIONER FIRESTONE: If we may turn to paragraph 12 on page 5, you deal, in this paragraph, with the more efficient use of personnel and you make the point that particularly in small hospitals physiotherapists are required to devote a good deal of their time to non-professional tasks.

My question to you is this: is it that there is not enough work for them to do as physiotherapists or are there financial considerations which make the non-professional use of physiotherapists necessary?

DR. BOTTERELL: I think one of our physiotherapy colleagues might answer.

MISS BRADSHAW: I think in the smaller hospital the time taken up by clerical duties and so on other than actually treating patients is a fairly large percentage of the time. It is not the lack of patients to be treated and we feel if we could be helped in this area it would be more efficient use of the physiotherapists.

DR. BOTTERELL: I think the answer is, there are lots of patients.

MISS BRADSHAW: Oh yes, the physiotherapist's time is taken up in part in doing clerical duties and other duties in running a department.

summary of our submission. Mr. Chairman, we should be happy to answer any questions you and your colleagues may wish to put.

MR. GRAHAM: Thank you very much, Mr. Cottrell.

MR. FRENCH: If we may turn to paragraph 12 on page 5, you deal, in this paragraph, with the more efficient use of manpower, and you make the point that particularly in small hospitals physiotherapists are required to devote a good deal of their time to non-professional tasks. My question to you is this: is it that there is not enough work for them to do as physiotherapists or are there financial considerations which make the non-professional use of physiotherapists

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[illegible]

Q. There are lots of patients.

MRS. MCDERMAN: Yes, the physiotherapist's time is taken up in part in doing clerical duties and other duties in lieu of a secretary.

DR. BOTTERELL: I am not a hospital administrator but I think they at all times feel that their budget is thin and if they can combine the professional and the housekeeping component that it is an economy.

COMMISSIONER FIRESTONE: Well now, is it? This is exactly the point we would like you to explain.

DR. BOTTERELL: We have gone on record that it is not, very firmly.

COMMISSIONER FIRESTONE: If I might understand it a little, the reason as to why a physiotherapist's time is used to do clerical work or housekeeping work; why?

DR. JOUSSE: There are certain requirements that have developed over the last few years and one of them is that the hospital commission wish to have an account of the number of units of treatment rendered and someone must fill in these documents and submit them.

Now, traditionally, when one has set up a department, one has obtained the service of physiotherapists and said, in effect, "You run the department" and they have taken on these duties willingly and have fulfilled them. These duties have been acceptable.

Now, one reason, as I have suggested, is keeping these records which could be kept pretty well by a secretary. As well, the general housekeeping department has not been called upon to clean special equipment perhaps for fear that they would damage it

administrator but I think they at all times feel that their budget is thin and if they can combine the professional and the housekeeping component that it is an economy.

MR. [illegible]: This is exactly the point we would like you to explain.

MR. MITCHELL: We have gone on record that it is not, very clearly.

MADAM CHAIRMAN PRESTON: If I might understand it a little, the reason as to why a physiotherapist's time is used to do clerical work or housekeeping work; why?

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and the therapists have assumed that responsibility.

One might easily conceive of a trained aide who could do that adequately and save the therapist's time.

COMMISSIONER FIRESTONE: You are making a convincing case but what I would like to know is why has that sort of division of labour not developed in fact?

DR. JOUSSE: I would say it was probably poor administration in the department and their failure to call the attention of the administration to the importance of this aspect of wastage.

COMMISSIONER FIRESTONE: Does the responsibility or the inadequacy lie with the therapist that runs his department or with the administration of the hospital?

DR. JOUSSE: With both, and with the doctor in between.

COMMISSIONER FIRESTONE: What do you suggest to overcome these inadequacies on the part of the administration, the doctor and the therapists? You just make a general recommendation and I am trying to understand how can one come to grips and deal with the problem.

DR. JOUSSE: One might obtain personnel, non-physiotherapeutic personnel, secretaries or a secretary and perhaps one who might train as an aide comparable to a nursing aide in educational background.

COMMISSIONER FIRESTONE: Are you suggesting the development of therapists' aides; is

and the therapists have served that responsibility.

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that a new group of people with semi-training? Is that what you have in mind?

DR. JOUSSE: That is suggested in here.

COMMISSIONER GIRARD: You are suggesting the training of aides and you do say that in physiotherapy, unlike nursing, there is not enough practical work, maybe not quite enough practical work for an aide. Did you not say something to that effect, that the aide in physiotherapy cannot be as completely useful as in nursing because there are not as many functions which she can perform? I agree with that.

Well, if this aide cannot perform as many functions in physiotherapy, could she not be this double person; I am talking now as an assistant administrator and thinking of the time, as any administrator, and about the budget? Could not this auxiliary person take on some of the clerical duties as well as some of the duties of the physiotherapist?

You did mention she could not take on too many functions of the physiotherapist because they are highly specialized so I would see this auxiliary as being maybe part clerical and part aide. Would that be feasible?

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/PB/ss

DR. BOTTERELL: Dr. Jousse could speak to that. In our committee we discussed this at great length and such activities are already going on.

DR. JOUSSE: In many hospitals, it depends on the size of the hospital, size of the department, the ratio of assistants to fully-trained therapists would never be as high as a similar group are with reference to the nursing staff. One person could fill the role, yes.

COMMISSIONER GIRARD: Have you gone as far as thinking what that ratio should be in physiotherapy as we have defined it in nursing, for instance?

MISS MARTIN: This is presently under study with the Canadian Physiotherapy Association. We have only discussed this informally and amongst ourselves and thought perhaps that the ratio would be about one aide to three qualified physiotherapists.

COMMISSIONER GIRARD: That was doing only physiotherapy functions.

MISS MARTIN: And housekeeping duties.

COMMISSIONER GIRARD: Housekeeping and clerical?

DR. BOTTERELL: That didn't include clerical?

MISS MARTIN: No, we were talking about housekeeping and assistance with treatment.

COMMISSIONER GIRARD: Would it be, and this is just a suggestion, would it not be better if she did clerical and physiotherapy work instead of housekeeping, because it is always easier in a hospital to get

Mr. MACMILLAN: Yes, Judge could speak to that. In our [illegible] we discuss this at great length and such activities are already going on.

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COMMISSIONER GIRARD: Would it be, and this is just a suggestion, would it not be better if the aid giving the physiotherapy work instead of housekeeping, because it is always easier in a hospital to get

people to do the housekeeping than to get clerical work. That is our experience.

COMMISSIONER BALTZAN: Does this type of person require a formal type of training or does she become suited by an apprenticeship method?

DR. JOUSSE: She would require purely training within the department. Considerable attention would be given to training in the details of the needs of that particular department which might vary from the needs of some other department.

DR. BOTTERELL: We visualize, sir, on the job training and are urging the Canadian Physiotherapy Association to work out a scheme to implement this.

COMMISSIONER BALTZAN: Thank you. That answers my question.

DR. BOTTERELL: I think it is fair, Mr. Chairman, to say this subject of delegation of responsibility is not always easy to introduce. The nurses were for a long time a little uncertain about the desirability of using nursing assistants and nursing aides, two grades of assistants, in our community, anyway, and it takes time to work out such a program.

COMMISSIONER FIRESTONE: In paragraph 24 you presented some estimates about future requirements of practising physiotherapists by 1970, and you mention as a conservative estimate 2,774 and perhaps a more realistic estimate of 3,000 to 3,500. Are these based on the assumption of the practice of physiotherapy as it exists, or have you taken into account that it might

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improve if a better team approach is developed between the physiotherapists and the auxiliary personnel?

DR. BOTTERELL: We have taken that fully into consideration.

COMMISSIONER FIRESTONE: It is based on the assumption there will be an improvement and a cooperative effort and if such an improvement were not to take place, this estimate would be on the low side?

DR. BOTTERELL: That is right, the conservative estimate would be on the low side.

COMMISSIONER FIRESTONE: And the 3,000 to 3,500 would still be a realistic estimate even though there might not have been the progress and cooperation between the physiotherapists and the auxiliaries?

DR. BOTTERELL: Most realistic, and I should point out, Mr. Chairman, we haven't deducted from the total the diplomates who might go back for graduate training. This would further reduce the number of physiotherapists in practice.

COMMISSIONER FIRESTONE: This then, sir, is a realistic estimate, the target you feel Canada should meet to provide adequate service.

DR. BOTTERELL: The answer to that, sir, is unequivocally yes. I think I speak for the group. Mr. Dunlop, would you like to comment on that?

MR. DUNLOP: Even if this target is achieved, sir, it will be until 1980 before we reach the ratio of therapists to population such as has been achieved in the United Kingdom and even there the ratio has proved to be inadequate.

[illegible]

[illegible] If a better team approach is developed between the [illegible] and the auxiliary personnel

MR. [illegible]: We have taken [illegible] fully into consideration.

[illegible] QUESTION: It is based on the assumption that there will be a improvement and a cooperative effort and if such an improvement were not to take place, this entire work is on the low side?

MR. [illegible]: That is right, the cooperative method would be on the low side.

[illegible] to [illegible] would seem be a realistic estimate even though they might not have been the progress and cooperation between the [illegible] and the auxiliaries?

MR. [illegible]: Most realistic, and I could point out, Mr. Chairman, we haven't received from the total the [illegible] who might be back to graduate [illegible]

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CONGRESSMAN [illegible]: This then, sir, is a realistic estimate, the target [illegible] should meet to provide adequate service.

MR. [illegible]: The answer to the, sir, is definitely yes. I think I speak for the group. I mean, [illegible] comment on that

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COMMISSIONER FIRESTONE: That is a very helpful comment. Thank you very much.

THE CHAIRMAN: You have these objectives. Where are the bodies going to come from?

DR. BOTTERELL: Well, sir, what we refer to in this brief about new schools is a vital part of this concept, because Dr.Jousse who is the Director of the school in Toronto and other directors have written in and will tell you and Dr. Jousse can expand this, that most of the girls who enter schools of physiotherapy come from the surrounding neighbourhood. They don't travel far, because of the expense that is involved, the expense of living away from home and so on; that is one of the reasons for starting a number of schools of not too great a size in appropriate areas of population. The average life expectancy of practising physiotherapy is three years.

THE CHAIRMAN: You mean life?

MISS BRADSHAW: Practising life.

DR. BOTTERELL: They are engaged in a different life, creating life. An unknown factor we have made an assumption about is the continuing import of physiotherapists from the United Kingdom, but Mr. Dunlop can tell you about the vacancies in their establishments.

MR. DUNLOP: About 1,000 vacancies in the United Kingdom. This worries us as to the continuation of immigration as a source of physiotherapists in the future.

THE CHAIRMAN: Now, Dr.Jousse, are there

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MR. [illegible]: That is a very helpful comment. Thank you very much.

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tives. Where are the ladies going to come from?

DR. [illegible]: Well, say, what we refer to in this brief about [illegible] schools is a usual part of this concept, because Dr. Jones who is the director of the school in Toronto and other directors have written in and will tell you and Dr. Jones can expand this, that most of the girls who enter schools of physiotherapy come from the surrounding neighbourhood. They don't travel far, because of the expense that is involved the expense of living away from home and so on; that is one of the reasons for starting a number of schools of not too great a size in appropriate areas of population. The average life expectancy of practising physiotherapy is three years.

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MR. DUNLOP: About 1,000 vacancies in the United Kingdom. This concerns us as to the continuation of immigration as a source of physiotherapists in the future.

MR. CHAIRMAN: Now, Dr. Jones, are the

more applicants than places in the present schools?

DR. JOUSSE: Mr. Chairman, in the last two years the applicants have reached the saturation point in Toronto. Last year when the study was initiated I surveyed various schools across the country and I think I recall this from memory, but I believe many of the schools were not fully saturated with students. However, schools have noted an increase in registration in the last year or so. These figures are based on the total number of students which can be accommodated by these various schools now presently in existence if every position were filled.

DR. BOTTERELL: Could Dr. Jousse say if he knows if they are filled up during the last year, 1961-1962?

DR. JOUSSE: No, they are not, not in Toronto either. We have a very small year of about fifty. We are able to enrol over one hundred in the first year. The graduate year is around fifty, but I think that is, I hope, the last of the small years.

DR. BOTTERELL: That was the pattern in medicine, the low point in the registration in the United States and Canada where there were vacancies on many faculties of medicine. I am not sure of the year I think it is the graduating class.

THE CHAIRMAN: 1956, 1957.

DR. BOTTERELL: It has gone to physiotherapy.

THE CHAIRMAN: Your view is if the school is made more local there would be far more applicants.

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MR. CHAIRMAN: Dr. Ian?

DR. MITCHELL: It has been so physics.

MR. CHAIRMAN: Your view is if the school is made more local there would be far more applicants

DR. JOUSSE: The schools must be brought to centres of population from which candidates can be recruited. I believe it is not possible to simply increase the size of the existing schools, because of the economic factors involved, the cost of travel, cost of living away from home.

COMMISSIONER McCUTCHEON: I take it, Dr. Botterell, starting the 1st of July you will get Queen's University to have a school?

DR. BOTTERELL: That depends, Mr. Chairman, upon the recommendations being successful and the large subsidization Queen's will get.

COMMISSIONER BALTZAN: Just one question, Dr. Botterell, on Page 3 -- 11, your recommendation is for improving physiotherapy services. Part 2 reads, improved prescription direction and supervision of physiotherapy and I think you inserted improving prescription by ---?

DR. BOTTERELL: Doctors.

COMMISSIONER BALTZAN: That is what I was missing.

DR. BOTTERELL: It is in this submission, but not in that one, sir.

COMMISSIONER GIRARD: Mr. Chairman, I hate to accept this high mortality rate of physiotherapists after three years. That is what we call it in nursing. the mortality rate, but surely you must do something to bring back married women into physiotherapy as we have done in nursing.

MISS MARTIN: If I may speak to this,

brought to centers of population from which candidates can be recruited. I believe it is not possible to simply increase the size of the existing schools, because of the economic factors involved, the cost of travel, cost of living away from home.

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DR. BOUTKELL: Correct.

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MR. [illegible]: ate to accept this high mortality rate of physiotherapis after three years. That is what we call it in nursing. the mortality rate, but surely you must do something to bring back nursing women into physiotherapy as we have done in nursing.

there is a great effort to bring married physiotherapists back and a great many are coming back, but they are taken into account in the 20, 25% who remain active in the practice of the profession and that accounts for those who are re-entering and leaving.

COMMISSIONER GIRARD: Do they come back in large numbers or is there a few?

MISS MARTIN: Well, relatively few. It is interesting, I think, we compared these statistics with those of a study of the nursing profession, the name of which I am sorry I cannot recall, and it was quite evident that the nursing profession also had about 25% continuing after four or five years.

COMMISSIONER GIRARD: There are some provinces where the number of married women in the profession is 50% and in some instances almost 60, so I think they come back to a large extent now in nursing.

MR. DUNLOP: The nursing study Miss Martin is referring to was a study done by the Canadian Nurses' Association for the Royal Commission on Canada's Economic Prospects and was done on a ten-year basis and the rate of attrition was about 13% per annum. The approach taken here by this group and it is expanded in the footnote on Page 11 is a somewhat different one, but we also calculate physiotherapists on a ten-year basis and the average attrition was 13% per annum. It came out about the same.

COMMISSIONER GIRARD: The number you lost, but do you have the number that came back after five, ten or twelve years?

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COMMISSIONER (DAVIS): There are some occasions where the number of married women in the profession is 40% and in some instances almost 60, so I think they come back to a large extent now in nursing.

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COMMISSIONER DAVIS: The number you lost, but do you have the number that came back after five, ten or twelve years?

MR. DUNLOP: We haven't got comparable statistics available to us.

MISS MARTIN: I think another factor in this is it is a young profession in Canada and that we think we may have a higher proportion of married therapists coming back to the profession, the number practising has increased tremendously since World War II.

DR. BOTTERELL: Can you recall the figures?

MISS BRADSHAW: I can't tell, I know they were small figures. A great many married people don't come back into the profession because it puts themselves and their husband into a higher income bracket from the point of view of income tax. That is one thing which I think, I have no statistics to prove it, but I think that is in part true.

THE CHAIRMAN: It is a misconception.

COMMISSIONER GIRARD: A lot of young nurses marry internes or medical students so the nurses have to come back to work to support the medical students until they finish. That is why we get so many back.

MISS BRADSHAW: That is true with physiotherapy.

MR. DUNLOP: The present practising physiotherapists in Canada are rather recent graduates and many of them haven't yet completed this process of generating a family and being able to put them out safely while they go back to work.

DR. JOUSSE: I think, Mr. Chairman, that we find in marriage a high percentage of the therapists

MR. MILLER: We haven't got comparable statistics available to us.

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MR. HUNTER: The present practising physiotherapists in Canada are rather recent graduates and many of them haven't yet completed this process of generating a family and being able to put their sons and daughters to school.

MR. [illegible]: [illegible] that we find in marriage a high percentage of the therapi

do work for a time, but I am only aware of one or two who have come back after that. Therefore it mounts up. Many nurses do return to the profession then.

THE CHAIRMAN: What about the men in the profession?

DR. BOTTERELL: We had hoped you would ask us that sir. I don't know who should answer your question. Perhaps Dr. Jousse. He runs a school.

DR. JOUSSE: Well sir, we have been willing to accept men as students at Toronto for I think about ten years. The applications we have received have come from men who are not academically fully qualified. The enquiries we have received have not been pursued by those I would judge might have been qualified once they enquired as to the salary rate.

THE CHAIRMAN: I suppose that may well be the real reason. The salary range for men and women would be the same?

DR. JOUSSE: That is correct, basically.

COMMISSIONER McCUTCHEON: Have you graduated any men?

DR. JOUSSE: There have been none graduated since World War II. There were two or three trained about 1942 who still are in practice. The rate of attrition isn't so great.

DR. BOTTERELL: In the discussions this Committee held on this subject one other point was made, which is that one or two males surrounded by 90, or 80, or 60 young females find themselves very much in a minority position. That is sometimes embarrassing to them.

COMMISSIONER McCUTCHEON: A very enervating experience I would imagine.

THE CHAIRMAN: What about the men in the professors.

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DR. BUTTERFILL: In the discussions this Committee held on this subject one other point was made, which is that one or two males surrounded by 20, or so, or so young females find themselves very much in a minority position. That is sometimes uncomfortable to them.

MRS. GOODERHAM: A very observation experience I would imagine.

THE CHAIRMAN: What about the private practice of physiotherapy?

MISS BRADSHAW: There are relatively few in private practice.

THE CHAIRMAN: We always have to go back to Saskatchewan for basic figures. We know that in Saskatoon there is a very well known physiotherapist there who operates a clinic with very great success. He is one of the men in the business who we know.

DR. JOUSSE: I know of possibly a dozen, mostly married women, who are physiotherapists in the City of Toronto, who carry on private practice, and whom I use considerably for the treatment of patients at home, in order that they may receive the treatment they might have received in hospital in Toronto, if they had not been encouraged to go home in order to free the bed, and that facility is available and is utilized quite fully, but that is not a large number for a city the size of Toronto.

COMMISSIONER McCUTCHEON: What kind of an income would they make?

DR. JOUSSE: Their fees range from four, five, six dollars a treatment, but I don't know what the actual income would be, or how busy they are.

COMMISSIONER McCUTCHEON: A treatment would take how long?

DR. JOUSSE: Half an hour to an hour, and of course travelling time would be extra.

THE CHAIRMAN: That is going from house to house?

THE CHAIRMAN: What about the private practice of physiotherapy?

MRS. RANSHAW: There are relatively few in private practice.

THE CHAIRMAN: We always have to go back to Saskatchewan for basic figures. We know that in Saskatoon there is a very well known physiotherapist there who operates a clinic with very great success. He is one of the men in the business who we know.

DR. JOUSSE: I know of possibly a dozen, mostly married women, who are physiotherapists in the City of Toronto, who carry on private practice, and whom I use considerably for the treatment of patients at home, in order that they may receive the treatment they might have received in hospital in Toronto if they had not been encouraged to go home in order to free the bed, and that facility is available and is utilized quite fully, but that is not a large number for a city the size of Toronto.

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COMMISSIONER McCUTCHEON: A treatment would take how long?

DR. JOUSSE: Half an hour to an hour, and of course travelling time would be extra.

THE CHAIRMAN: That is going from house to house.

DR. JOUSSE: That is right, they must have a car.

MISS MARTIN: Some private physiotherapists have their own offices.

THE CHAIRMAN: The one that I was referring to has his own building.

MISS MARTIN: And I certainly believe that there are a great deal of untapped opportunity for the private practice of physiotherapy, as in many other fields such as industry, and in home care services, and services that haven't really been explored to any great extent.

COMMISSIONER VAN WART: In section 57, the last sentence reads:

"A high priority should also be given "to meeting the needs of institutions "which have a high proportion of "patients suffering from severe dis- "abilities such as convalescent "hospitals, rehabilitation centres, "and chronic disease hospitals."

Would you expand on that?

DR. BOTTERELL: Some years ago at a meeting sponsored by the government of Canada in Toronto there was a large discussion on rehabilitation generally, and at that time it became clear that what was needed was to teach physiotherapists, and all the other paramedical workers, vocational guidance counsellors and occupational therapists, and everybody else, their part in a team effort to help patients rehabilitate themselves,

Mr. [illegible]: That is right, they must

[illegible]

therapists have their own offices.

[illegible]

[illegible]

that there are a great deal of untapped opportunity for the private practice of physiotherapy, as in many other fields such as industry, and in home care services, and services that haven't really been exploited to any great extent.

COMMISSIONER VAN WART: In section 27, the last sentence reads:

"A new priority should also be given to meeting the needs of institutions which have a high proportion of patients suffering from severe disabilities such as cerebral palsy, multiple sclerosis, and chronic cardiac hospitals."

Would you comment on that.

DR. [illegible]: These years ago at a meeting sponsored by the government of Canada, in Toronto there was a lengthy discussion on rehabilitation generally, and at that time it became clear that what was needed was to bring physiotherapists, and all the other paramedical workers, social workers and occupational and rehabilitation therapists, and psychiatric aids, into a team effort in such a way that the patient

[illegible]

because we don't rehabilitate patients, they do it themselves, and it became clear to us who were involved in training doctors that these young men really didn't get a very firm grasp of what the rehabilitation team, and particularly the physiotherapists we are discussing now, could do for patients, so that the highest priority for the creation of first-class departments of physiotherapy and all the other members of the rehabilitation team, should be in the institutions which are teaching not only physiotherapists, but other paramedical personnel, and under-graduate and graduate medical students, post-graduate medical training for doctors if you like, and their residency training programs.

THE CHAIRMAN: In the under-graduate training programs, I don't know if you were in this morning. That was being discussed this morning and particularly stress was being laid on the rotation the under-graduate should have.

DR. BOTTERELL: This particularly concerns medical interns and residents, because they are working with the attending staff in what aspires to be exemplary treatment of patients, and if these young men and women can participate in the total treatment of the patient, not just the acute treatment, but in his beginning rehabilitation, they will then go out into the practice of medicine, and they will prescribe and supervise physiotherapy in a way that they would never be able to do following any other type of training.

This, if you want to call it, is perhaps the education that a health centre or a team where

because we don't rehabilitate patients, they do it themselves, and I feel very clear to us who were involved in training doctors that these young men really did it and a specialist named at the top [illegible]

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Dr. [illegible]: In the under-graduate training program, I don't know if you were in this morning. That was being discussed this morning and particularly stress was being laid on the rotation the under-graduate should have.

[illegible]

concerns medical patients and residents, because they are working with the attending staff in what appears to be exemplary fashion of medicine, and if these young men and women can participate in the total treatment of the patient, not just the acute treatment, but in this beginning rehabilitation, they will then go out into the practice of medicine, and they will prescribe and supervise physiotherapy in a way that they would never be able to do if [illegible] any other type of training.

Now, if you want to call it, as [illegible] the [illegible] the health centre, or a team [illegible]

the whole team is involved in the treatment of a patient under exemplary and ideal circumstances, and once we can get physiotherapists and doctors and occupational therapists and the rest working as a team in this teaching institution, the results will radiate out like the spokes of a wheel, into the non-teaching hospital, the smaller hospital, and general practice.

That is why we gave this high priority to institutions, general hospitals, rehabilitation centres, chronically ill hospitals, which are affiliated with faculties of medicine.

THE CHAIRMAN: As you know, Dr. Botterell, we have the medical education committee, a team working for the Commission, and many of your recommendations will go directly to Dr. MacFarlane's Committee, and Dr. Ettinger is connected with it, so that we are looking for great things from them.

DR. BOTTERELL: I think you will get them too sir. I have been engaged in discussions with them.

THE CHAIRMAN: We believe that. I know they are receptive. They are looking for ideas in connection with medical education in all its branches from any place it may be forthcoming.

Thank you very much Dr. Botterell. Perhaps before you leave I might say that we just had word a few minutes ago, I think we were all anxious when we started the discussion at two o'clock about the astronaut Scott Carpenter. He has been recovered.

DR. BOTTERELL: Thank you very much

the whole team is involved in the treatment of a patient under psychiatry and local circumstances, and once we can get physiotherapists and doctors and occupational therapists and the best working as a team in this teaching institution, the results will radiate out like the spokes of a wheel, into the non-teaching hospital, the smaller hospital, and general practice.

That is why we gave this high priority to institutions, general hospitals, rehabilitation centres, chronically ill hospitals, which are affiliated with faculties of medicine.

THE CHAIRMAN: As you know, Dr. Rotterell, we have the medical education committee, a team working for the commission, and many of your recommendations will go directly to Dr. Macfarlane's Committee, and Dr. Ettinger is connected with it, so that we are looking for great things from them.

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THE CHAIRMAN: We believe that. I know they are receptive. They are looking for ideas in connection with medical education in all its phases from any place it may be forthcoming.

Thank you very much Dr. Rotterell. Before you leave I might say that we just had word a few minutes ago, I think we were all anxious when we started the discussion at two o'clock about the assistant Scott Paperman. He has been recovered.

DR. ROTTERELL: Thank you very much

sir.

THE SECRETARY: Mr. Chairman, the next submission is that of the Board of Directors of Physiotherapy, and will be known as exhibit 315, and Mrs. Macpherson will come forward and introduce her group and read her conclusions and recommendations.

---EXHIBIT NO. 315: Submission of the Board of Directors of Physiotherapy.

SUBMISSION OF

THE BOARD OF DIRECTORS OF PHYSIOTHERAPY OF ONTARIO

APPEARANCES: Mrs. K.M. Macpherson
Miss M. Harland
Miss C.E. Cunningham.

MRS. MACPHERSON: Mr. Chairman, I would like to introduce my colleagues. On my left is Miss Harland, of the School of Physiotherapy of the University of Toronto, and Miss Cunningham, Chief Physiotherapist of the Joseph Brant Memorial Hospital in Burlington.

Mr. Chairman, and Members of the Commission:

1. This submission is respectfully made to the Royal Commission on Health Services in Canada by the Board of Directors of Physiotherapy for the Province of Ontario. This Board is the body authorized by the Drugless Practitioners Act of Ontario to make regulations governing the registration of all those

sir.

MR. CONSTABLE: Mr. Chairman, the next submission is that of the Board of Directors of Chiropodists of Ontario, and it will be known as exhibit 310, and Mrs. Vandelsen will come forward and introduce her group and read her recommendations.

---EXHIBIT NO. 310: Submission of the Board of Directors of Chiropodists of Ontario.

SUBMISSION OF

THE BOARD OF DIRECTORS OF CHIROPODISTS OF ONTARIO

APPEARANCES: Mrs. K. M. Vandelsen
Miss M. Harland

MRS. VANDELSEN: Mr. Chairman, I would like to introduce my colleagues. On my left is Miss Harland, of the School of Chiropodists of the University of Toronto, and Miss Cunningham, Chief Chiropodist of the Joseph Brant Memorial Hospital in Burlington.

Mr. Chairman, and Members of the Commission:

1. This submission is respectfully made to the Royal Commission on Health Services in behalf of the Board of Directors of Chiropodists of Ontario for the Province of Ontario. This board is the body authorized by the Chiropodists Act of Ontario to make representations regarding the registration of all those

practising physiotherapy in Ontario, to set and maintain standards of training, ethics, practice and discipline for those physiotherapists practising in the Province, and by so doing, to protect the public from treatment administered by unqualified persons.

2. We propose to discuss the following points:

1. Numbers and distribution of physiotherapists in Ontario;
2. Training schools in Ontario;
3. Cost of Training;
4. Bursaries and Scholarships;
5. Salaries;
6. Ontario Hospital and other Insurance plans;
7. The Drugless Practitioners Act of Ontario;

3. CONCLUSIONS AND RECOMMENDATIONS

Conclusions and recommendations relating to the foregoing points can be summarized as follows:

4. 1. Numbers and Distribution

There are 500 Registered Physiotherapists in Ontario. It is estimated that 200 more are needed now. The one training school in the Province, together with Physiotherapists coming in from outside, cannot possibly meet this need. Facilities for training more physiotherapists must therefore be increased.

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2. We propose to discuss the following points:

1. Numbers and distribution of physiotherapists in Ontario;
2. Training schools in Ontario;
3. Cost of Training;
4. Bursaries and Scholarships;
5. [illegible];
6. Ontario Hospital and other Insurance plans;
7. The Drugless Practitioners Act of Ontario;

3. CONCLUSIONS AND RECOMMENDATIONS.

Conclusions and recommendations relating to the foregoing points can be summarized as follows:

1. Numbers and Distribution

There are 500 Registered Physiotherapists in Ontario. It is estimated that 100 more are needed now. The one training school in the Province, together with Physiotherapists coming in from outside, cannot possibly meet this need. Facilities for training more physiotherapists must therefore be increased.

5. 2. Training Schools

The majority of physiotherapists trained at the University of Toronto work in and around the City of Toronto. If schools of physiotherapy were established at the Universities of Western Ontario, Queen's and Ottawa, they would provide a much needed source of personnel in and around these centres.

6. 3. Cost of Training

The cost of establishing a school of physiotherapy under the Faculty of Medicine of a university varies with circumstances but can be less than $50,000.00, with salaries for the first year estimated at an additional $25,000.00. Cost per student to the university is $1,600.00 net or less. Annual cost of training to the student is $2,000.00 (including living costs).

I am afraid, Mr. Chairman, this may sound repetitious after what you have heard. This is from our point of view.

7. 4. Bursaries and Scholarships

To enable more students to train as physiotherapists more bursaries and scholarships must be offered by government departments, organizations and communities needing their services. The training of teachers must also be assisted.

8. 5. Salaries

Higher salaries will attract more physiotherapists, particularly for hospitals, and may also attract more men, who cannot often support families on the present salaries. Married women might be attracted

[illegible]

training at the University of [illegible] and around the city of [illegible]. If schools of [illegible] were established at the [illegible] sites of [illegible], [illegible]'s and Ottawa, they would provide a [illegible] source of personnel in and around these centres.

3.

The cost of establishing a school of [illegible] medicine in the locality of [illegible] University's various [illegible] would be less than $[illegible], [illegible] a year. [illegible] estimated as an additional $[illegible] cost per student to the university [illegible] per year. [illegible] cost of training in the student [illegible] (including living costs)

I am [illegible], Mr. [illegible], [illegible] may [illegible] repetitious [illegible] you have [illegible]. This is [illegible] own point of view.

7. [illegible] Accreditation [illegible]

To [illegible] [illegible] as [illegible] distinguishes more [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] and community [illegible] [illegible] [illegible]. The [illegible] of [illegible] [illegible] be [illegible].

8. [illegible] Fees

[illegible] [illegible] [illegible] [illegible]

back into the profession if income tax concessions could be made.

9. 6. Insurance Plans

Ontario Hospital and other Insurance Plans would better serve the public if physiotherapy treatment could be included in them, when given either in the Out-patient department or outside the hospital by a Registered Physiotherapist.

10. 7. Drugless Practitioners' Act

The physiotherapy profession is the only one of the five categories governed by the Drugless Practitioners' Act of Ontario whose members work solely under medical direction. If the profession operated under a separate Act of the Legislature, it would be better able to protect the public from treatment given by unqualified workers.

This is respectfully submitted, sir.

THE CHAIRMAN: Now, Mrs. Macpherson, about this matter of unqualified workers, to start right at the bottom, are you plagued with such?

MRS. MACPHERSON: We are not plagued, sir, but it is our responsibility to ---

THE CHAIRMAN: Is it a concern at all?

MRS. MACPHERSON: Yes, it is certainly a concern of ours, because we are required, as a Board ---

THE CHAIRMAN: I mean as a practical matter. Are there people holding themselves out as physiotherapists who are not?

MRS. MACPHERSON: Yes. It does not happen too many times, but we certainly encounter it

several times in the course of a year. We have elaborated a little bit more on this particular point on page 9, particularly the necessity for supervision by the medical profession in ordering treatment and prescribing therapy.

THE CHAIRMAN: You say in 6, about the insurance plans, that they would better serve the public if physiotherapy treatment could be included in them, whether given in the out-patient department or outside the hospital. We have the position where physiotherapy is covered with the in-patient. How would you foresee the hospital insurance plan covering the cost of physiotherapy treatment outside the hospital?

The out-patient department may be much easier to visualize.

MRS. MACPHERSON: Yes, this might be the first step.

THE CHAIRMAN: What about outside the hospital?

MRS. MACPHERSON: I believe it has been suggested at the request of a hospital that this treatment might be procured for a patient leaving hospital. That might be one step.

THE CHAIRMAN: By whom would this service be rendered?

MRS. MACPHERSON: It would be rendered by a registered physiotherapist outside the hospital team.

THE CHAIRMAN: Somebody practising in private practice?

several times in the course of a year. We have elaborated a little bit more on this particular plan on page 3, particularly the necessity for supervision by the medical profession in ordering treatment and prescribing therapy.

The insurance plan, that the, would better serve the public if physiotherapy treatment could be included in them, whether given in the out-patient department or outside the hospital. We have the position where physiotherapy is covered with the in-patient. Now would you increase the hospital insurance plan covering the cost of physiotherapy treatment outside the hospital? The out-patient department may be much easier to visualize.

MRS. JACOBSSON: Yes, this might be the first step.

THE CHAIRMAN: What about outside the

MRS. JACOBSSON: I believe it has been suggested at the request of a hospital that this treatment might be procured for a patient leaving hospital. That might be one step.

MR. CHAIRMAN: By whom would this service be rendered?

MRS. JACOBSSON: It would be rendered by a registered physiotherapist outside the hospital.

[illegible]

private practice?

MRS. MACPHERSON: Either in private practice or in the physiotherapy clinic as such, that sort of set-up.

THE CHAIRMAN: The clinic would be private practice?

MRS. MACPHERSON: Yes, usually. I am thinking partly in terms of the Arthritis Society and some of the services which are gradually coming into being where patients are treated in the home, not necessarily on a private basis.

THE CHAIRMAN: But in that case does the patient pay, pay the cost of the treatment?

MRS. MACPHERSON: This, I think, I should refer to the members of the Arthritis Society, who are in the audience still, I believe. I am not too familiar as to their particular form.

THE CHAIRMAN: If this is outside the scope of your submission, we will deal with it otherwise.

In the out-patient department, of course, it will be by somebody on the staff of the hospital?

MRS. MACPHERSON: Yes.

THE CHAIRMAN: And that would go right into the hospital budget and be absorbed that way?

MRS. MACPHERSON: That is right. There might be a comparable situation, sir, in that the Workmen's Compensation Board does allow for physiotherapy treatment in the home given by registered physiotherapists and this might be a comparable situation with a similar arrangement under the hospital insurance

practice on in the convalescent clinic as soon, that

THE CHAIRMAN: The clinic can't be

private, that's

I am thinking partly in terms of the Arthritis Society and some of the [illegible] which are gradually coming into being where patients are treated in the home, not necessarily on a private basis.

THE CHAIRMAN: But in that case does the patient pay, per the cost of the treatment?

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THE CHAIRMAN: If this is outside the scope of your [illegible], we will deal with it otherwise in the out-patient department, of course, it will [illegible] somebody on the staff of the hospital?

MR. [illegible]: Yes.

THE CHAIRMAN: And that would go right into the hospital budget and be absorbed that way?

MR. [illegible]: That is [illegible]

There might be a [illegible] situation, sir, in that the [illegible] commission board does allow for physiotherapy treatment in the home given by registered physiotherapists and this might be a [illegible] situation [illegible] under the hospital insurance

plan.

THE CHAIRMAN: Or could it be established under P.S.I.?

MRS. MACPHERSON: I would think so. In fact, I believe there are some insurance companies which include physiotherapy treatment given outside a hospital.

THE CHAIRMAN: The commercial insurers?

MRS. MACPHERSON: Yes.

THE CHAIRMAN: In 8, this matter of income tax concessions to attract married women back into the profession; just what have you in mind by way of practical suggestion there?

MRS. MACPHERSON: As you know, the allowance for a married woman before her husband's allowance of $1,000 for his dependent wife starts to be deducted, she is allowed to earn $250. We were thinking in terms of possibly allowing a greater amount to be earned by a married woman before her husband's tax is sent up into another category and his exemption is lowered by the $250 or whatever it is.

THE CHAIRMAN: You make that blanket proposition, or do you only want to relate it to physiotherapists?

MRS. MACPHERSON: I don't think it is practical to do it only for one profession. There are a number of professions which need married women coming back into them. It was made as a suggestion that might possibly help a number of professions in this regard.

Mr. [illegible]: Or could it be

[illegible]?

In fact, I believe there are some insurance companies which include physiotherapy treatment, even outside a hospital.

Mr. [illegible]: The commercial insurers?

Mrs. MACDONALD: Yes.

THE CHAIRMAN: In 8, this matter of income tax concessions to attract married women back into the profession, just what have you in mind by way of practical implementation there?

Mrs. MACDONALD: As you know, the allowance for a married woman before her husband's allowance of $1,000 for his dependent wife stands to be deducted, she is allowed to earn $250. We were thinking in terms of possibly allowing a greater amount to be earned by a married woman before her husband's tax is sent up into another category and his exemption is lowered by the $1000 or whatever it is.

[illegible]: You mean that clause?

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[illegible]: I don't think it is practical to do it only for one profession. [illegible] a number of professions which need married women coming back into them. It was made as a suggestion that it might possibly help a number of professions in [illegible]

MISS HARLAND: If a married woman goes out of the home back to her profession she invariably needs a little more help in the home and has to pay for that help, and then she doesn't get enough from the $250 to really warrant going back into her profession again; it is not worth her while in dollars and cents, certainly.

COMMISSIONER FIRESTONE: If I may follow up the point that the Chairman raised, Mrs. Macpherson, in connection with your recommendation 6 on page 2, are there adequate facilities in Ontario hospitals to give physiotherapy treatment in out-patient departments?

MRS. MACPHERSON: Perhaps Miss Cunningham could answer that.

MISS CUNNINGHAM: It does create a strain on the department. I am the supervisor in the department in a 250-bed hospital. If we do 90 patients, possibly 40 of them would be out-patients. I don't know whether you gentlemen are familiar with the fact that a hospital does not get to keep the money made in the physiotherapy department under the O.H.S.C.

If my physiotherapy department allowance is $10,000 this year, this is deducted from the grant to the hospital next year.

THE CHAIRMAN: It is revenue to the hospital?

MISS CUNNINGHAM: From an administrative standpoint the administration is not too concerned whether we are worried about out-patients or not. We

Mrs. [illegible]: It's a [illegible] [illegible]
[illegible] out. If the [illegible] back to her professor who
invariably needs a little more help in the home and
has to pay for that help, and then are [illegible] not
enough from the [illegible] to really warrant [illegible] [illegible]
dollars and cents, currently.

Follow up the point that the chairman raised, Mrs.
Macpherson, in connection with your recommendation 6
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[illegible]

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Mrs. [illegible]: It does create a
strain on the department. I am the supervisor in the
department in a 125-bed hospital. I've [illegible] patients,
roughly 40 or 50 can work in out-patients. I don't
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that a hospital does not get to keep the money [illegible] in
the physiotherapy department under the [illegible].

If my physiotherapy department allowance
is $10,000 this year, this is deducted from the grant
to the hospital next year.

Mr. [illegible]: It is revenue to the
hospital.

Mrs. [illegible]: Your amendment [illegible]
[illegible] the administration is not too concerned
whether we are working about out-patients or not. We

are there to do the in-patients. If we have the time and energy to do the out-patients, so much the better.

We do our level best to provide a service in the community to take out-patients, but the average physiotherapy department is so under-staffed and the facilities so taxed that it is difficult to maintain much of an out-patient service.

COMMISSIONER FIRESTONE: Wouldn't it be in the interests of economy to have adequate facilities, both in out-patient departments, to perform these functions? Presumably it might be possible to release some patients earlier to release some beds and say, "Come back tomorrow or the day after and get treatment in our out-patient department."

Would not that recommendation have really two effects: 1. You would provide a necessary service; 2. It might turn out to be an economy move?

MISS CUNNINGHAM: Yes.

COMMISSIONER FIRESTONE: Or, if not, it would relieve pressure on the beds.

MISS CUNNINGHAM: You are quite right, sir. But it is not an economy for the patient if he has to pay for it. If it is a post-op case, say, if it is a post-op disc, the patient cannot trot out to the bus stop to come in. This is provided by a number of friends, relatives and neighbours, etc. We have an auxiliary where a patient cannot get transportation; this is provided for them.

COMMISSIONER FIRESTONE: On the first point that the patient pays for the service if he is an

are there to do the investigations. If we have the time and energy to do the out-patients, so much the better. We do our level best to provide a service in the community to take out-patients, but the average physiotherapy department is so under-staffed and the facilities so taxed that it is difficult to maintain much of an out-patient service.

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Would not that recommendation have really two aims: 1. You would provide a necessary service; 2. It might turn out to be an economy novel?

COMMISSIONER FIRESTONE: Or, if not, it would relieve a pressure on the beds.

MR. GUGGENHEIM: You are quite right, sir. But it is not an economy for the patient if he has to pay for it. If it is a post-[illegible] case, say, it is a pre-[illegible] case, the patient cannot trot out to the hospital to come in. This is provided by a number of [illegible], [illegible] and [illegible], etc. We have an auxiliary where a patient cannot get transportation; this is provided for.

COMMISSIONER FIRESTONE: On the first point that the patient pays for the service if he is an

out-patient, and he does not pay for it directly if he is an in-patient, the fact still remains that as far as the community is concerned, it is costing much more to keep a patient in the hospital, wherever the funds come from. So if we are talking in terms of economy of a nation or a province, it would be an actual saving to the hospital insurance plan to introduce the other system or the system that you recommend.

MISS CUNNINGHAM: That is right.

COMMISSIONER FIRESTONE: But it raises the practical question of how long to stay in the hospital because they feel they are covered, than pay out of their own pocket.

MISS CUNNINGHAM: That is right.

COMMISSIONER FIRESTONE: So the implication of this would be that this service should be included, this out-patient service, should be included as part of the coverage under the hospital insurance plan?

MISS CUNNINGHAM: Yes, I think that is a very sensible suggestion.

MISS HARLAND: There is also the possibility that the patient, once he has left the hospital, if he has to pay for his own out-patient treatment perhaps he would not be able to get it because he can't afford it.

COMMISSIONER FIRESTONE: What would be the position if he was an indigent person?

MISS CUNNINGHAM: If he is an indigent person the town welfare department pays part of the cost

out-patient, and he does not pay for it directly if he is an in-patient, the fact still remains that as far as the community is concerned, it is costing much more to keep a patient in the hospital, wherever the funds come from. So if we are talking in terms of economy of a nation or a province, it would be an actual saving to the hospital insurance plan to introduce the other system of the system that you recommend.

COMMISSIONER FINNEY: But it raises the practical question of how long to stay in the hospital because they just they are covered, then pay out of their own pocket.

MR. CUNNINGHAM: That is right.

COMMISSIONER FINNEY: So the implication of this would be that this service should be included, this out-patient service, should be included as part of the coverage under the hospital insurance plan?

MR. CUNNINGHAM: Yes, I think that is a very sensible suggestion.

MR. MACLAND: There is also the possibility that the patient, once he has left the hospital, it is hard to pay for his own out-patient treatment because he would not be able to pay it because he couldn't afford it.

COMMISSIONER FINNEY: What was the position if he was an indigent person?

MR. CUNNINGHAM: If he is an indigent person the town welfare department pays part of the cost

and the hospital writes off the rest. This is not provided in too many cases. But the average patient, if he is not a long-term rehabilitation - I am speaking of an active treatment centre, not a rehabilitation centre - he is not going to be coming in very long as an out-patient, possibly less than a month, and if need be he can probably spend that money himself.

COMMISSIONER FIRESTONE: Thank you.

COMMISSIONER STRACHAN: Mr. Chairman, I am wondering if the registered physiotherapists in private practice do so only under medical prescription?

MISS CUNNINGHAM: Yes, sir, they are supposed to.

COMMISSIONER STRACHAN: And in paragraph 33, what have you done to bring about a separate Act of provincial legislation regarding physiotherapists?

MRS. MACPHERSON: We have, so far, discussed this with our lawyers and with the legal department under the Department of Health. It hasn't got beyond that stage, beyond the fact that we have a basis for comparison in the Acts under which most of the other provinces operate their physiotherapists. But further than this we have not gone.

THE CHAIRMAN: Maybe we misunderstood one question, the import of it, but did you say there must be a referral by a doctor to a physiotherapist in private practice?

MISS CUNNINGHAM: Yes.

THE CHAIRMAN: Where do we find that?

Dunedin 1 pm

and the [illegible] of the rest. This is not provided in [illegible] cases. But the average patient, if he is from a long-term rehabilitation - I am speaking of an active treatment centre, not a rehabilitation centre - he is not going, if he comes in very long or in outpatients, possibly less than a month, and it need be he can probably spend that money himself.

I am working in the registered physiotherapists in private practice do so on [illegible] under medical prescription.

MRS CAMERON: Yes, sir, they are supposed to

COMMISSIONER STRACHAN: And in paragraph 24, what have you done to bring about a separate Act or provision for statutory regulating of physiotherapists

Discussed this with our lawyers and with the Department under the Department of Health. It doesn't get beyond that stage, beyond the fact that we have a basis for compulsion in the Act under which most of the other provinces complete their physiotherapists, but further than this we have not gone.

MR CHAPMAN: Maybe we might mention one question, the report of it, but did you say there was be a referral by a doctor to a physiotherapist in private practice?

MRS CAMERON: Yes.

MR CHAPMAN: Where do we find that?

MRS. MACPHERSON: It is in our regulations. I believe you have them. I am afraid I am not too familiar with the legal terminology and it takes quite a long time to sort out. But that is the implication on the first page where it deals with prescription.

COMMISSIONER McCUTCHEON: But there is a distinction there between physiotherapists registered prior to the 31st day of January, 1955; they may act without a doctor.

MRS. MACPHERSON: Yes.

cH/FF/ss

THE CHAIRMAN: Now, you heard the discussion that preceeded yours, do you have any observations, any remarks you want to make arising out of the questions and discussion that took place? You now get your chance to rebut or refute.

MRS. MACPHERSON: I do not think we would rebut anything that went on previously because we support it wholeheartedly in all its aspects with particular reference to Ontario. I might just add that in going over the students from last year's graduating class that, as we mentioned in our brief, 62% of the pupils remain in Toronto. We feel the only way to get a source of supply of interested students coming into the profession is by establishing schools in other centres of the province.

THE CHAIRMAN: Thank you very much.

THE SECRETARY: Mr. Chairman, the next submission is that of the Ontario Society of Physiotherapy and the brief will be known as Exhibit 316.

---EXHIBIT NO. 316: Submission of the Ontario Society of Physiotherapy.

S U B M I S S I O N O F

THE ONTARIO SOCIETY OF PHYSIOTHERAPY

APPEARANCES:

MR. R. F. CLARK,
MISS J.M. FAGAN.

THE CHAIRMAN: Yes, Mr. Clark?

Now, you heard the discussion that preceded yours, do you have any observations, any remarks you want to make arising out of the questions and discussion that took place? You now get your chance to refute or refute.

MR. MAGEE: I do not think we would result anything that went on over-lonely because we support it wholeheartedly in all its aspects with particular reference to Ontario. I might just add that in going over the studies from last year's graduating class that, as is mentioned in our brief, 60% of the people remain in Toronto. We feel the only way to get a source of supply of interested students coming into the profession is by establishing schools in other centres of the province.

MR. DR. THOMAS: Thank you very much.

Next submission is that of the Ontario Society of Physiotherapy and the brief will be known as Exhibit 34.

---EXHIBIT NO. 34: Brief filed by the Ontario Society of Physiotherapy.

O N T A R I O

MEDICAL ASSOCIATION

PRESIDENT:

DR. [illegible]

DR. CHARLES [illegible]

DR. [illegible]

MR. CLARK: I would like to introduce our President, Miss Jean Fagan from Hamilton.

1. HISTORICAL BACKGROUND OF THE ONTARIO SOCIETY OF PHYSIO-THERAPY

The Society issued Provincial Charter March 1926.

Constitution and By-Laws attached as Appendix "A".

2. THE CURRENT ROLE OF THE SOCIETY

2A Private Practitioners serving in the field

2B Serving in Institutions (Hospitals, W.C.B., Industry).

3. PROJECTIONS FOR THE FUTURE:

3A Consideration of Physiotherapy in any Health Plan.

3B Amend and unify Municipal By-Laws re private practice.

3C Co-ordinate Provincial Boards (Reciprocity) Standardize licencing requirements nationally.

3D Provide regular Post-Graduate seminars.

3E Develop more facilities to train male Therapists.

3F Encourage private practice in smaller centres.

3G Tax exemption on equipment to private practitioners (Same as Hospitals)

4. AUTHORITIES AND REFERENCES:

4A Canadian Conference on Physiotherapy 1 May 1961 (Statistical Supplement)

4B Ontario Hospital Services Comm. Annual Report 1960

4C Journal of American Hospital Assoc: 1960

4D Appendix "A" Attached, our Constitution.

tual understanding between the two fields or relations, somewhat more and a more closely-knit ---

[illegible]: The [illegible],

we always have to try to see whether these recommendations fit into or come near our terms of reference. This matter of doctor and therapist coordination would appear to be one an almost person to person level in that area that you are talking about now.

MR. CLARK: Well, as an example, in my own practice we have an ideal circumstance where I am known to the physicians in the area and they to me. We are able to discuss very closely the problems of our patients and it is a question of getting together of the practitioners in the field to produce some type of cooperation in a universal way.

THE CHAIRMAN: We have been discussing the male physiotherapists, we hear there are not many engaged in that profession.

MR. CLARK: That is true, unfortunately. I think the lowest salary schedules are low for a male; if you have to support a wife and family it becomes quite a problem.

THE CHAIRMAN: So they do not go into public professions as employees, they go in as private practitioners more than employees or as operators of clinics.

MR. CLARK: No, we do have practitioners employed in institutional work but it works out that [illegible] to allow them to maintain any sort of professional dignity.

[illegible]: [illegible] you also [illegible]

THE CHAIRMAN: Now, Mr. Clark, this tax exemption on equipment and a number of other items here that refer to private practice, I take it you are in private practice?

MR. CLARK: Yes, sir.

THE CHAIRMAN: Just what is the extent of private practice in Ontario?

MR. CLARK: We have some 56 members of which the bulk are in private practice in centres throughout the Province. In connection with the tax exemption, we as private practitioners have to pay a sales tax which is relieved from the hospitals in the purchase of equipment. We ask, to encourage more private practitioners, that some relief be given to allow us to purchase the most modern equipment available to give adequate treatment. These are based very closely to the hospital and as such we have the same circumstance in cost of operation and this works a hardship.

THE CHAIRMAN: This one phase, how would you encourage private practice in the smaller centres? The Toronto area appears to be taken care of.

MR. CLARK: Yes. Well, in our brief we have suggested that aid be given, financial assistance, through the medium of small interest loans and increased prescription and direction from the practising physicians in the area. There are two methods of encouragement.

THE CHAIRMAN: What do you mean by the second part, making the doctors aware where you are and what you are doing?

MR. CLARK: It is a question of awareness

Mr. Chairman, I would like to introduce

our President, Miss Joan Fagan from Hamilton

1. HISTORICAL MOMENTUM IN THE ONTARIO SOCIETY OF

MRSLT-.E.T.A.

The Society issued from the Charter March 1960.

Constitution and By-laws attached as Appendix "A".

2. THE CURRENT ROLE OF THE SOCIETY

2A Private Practitioners serving in the field

2B Serving in Institutions (Hospitals, N.C.H.P.,

3. PROJECTIONS FOR THE FUTURE.

3A Administration of Physiotherapy in any Health

3B Amend and unify Municipal By-laws re private

3C Co-operate Provincial Wards (Corporority)

Laboratory licensing requirements nationally

3D Develop more facilities so to train male

Therapists.

3E Encourage private practice in smaller centres

3F Lax exemption on equipment to private

practitioners (same as Hospitals)

ADMINISTRATIVE ACTIVITIES:

4A Canadian Co-licensure in Physiotherapy Policy

4B Ontario Occupational Therapists Guild Annual Report

4C Journal of American Physical Therapy

Appendix "A" Attached, see Constitution.

mutual understanding between the two fields of medicine, physiotherapy and a more closely-knit ---

THE CHAIRMAN: You see, Mr. Clark, we always have to try to see whether these recommendations fit into or come near our terms of reference. This matter of doctor and therapist coordination would appear to be on an almost person to person level in that area that you are talking about now.

MR. CLARK: Well, as an example, in my own practice we have an ideal circumstance where I am known to the physicians in the area and they to me. We are able to discuss very closely the problems of our patients and it is a question of getting together of the practitioners in the field to produce some type of cooperation in a universal way.

THE CHAIRMAN: We have been discussing the male physiotherapists, we hear there are not many engaged in that profession?

MR. CLARK: That is true, unfortunately. I think the largest problem is one of pay, because the salary schedules are low for a male; if you have to support a wife and family it becomes quite a problem.

THE CHAIRMAN: So they do not go into this profession as employees, they go in as private practitioners more than employees or as operators of clinics?

MR.CLARK: No, we do have practitioners we employ in institutional work but it works considerable hardship to allow them to maintain any sort of professional dignity.

MISS FAGAN: Would you like me to

tax exemption on equipment and a number of other items were that we on to private practice, I take it you are in private practice

MR. CHALLIES: Just what is the extent

MR. FRANK: We have some 50 members in which the bulk are in private practice in centres throughout the Province. In connection with the tax exemption, we do put the practitioners have to pay a sales tax which is returned from the hospitals in the purchase of equipment. We ask, to encourage more private practitioners, that some relief be given to allow us to purchase the most modern equipment available to give adequate treatment. Cases are based very closely to the hospital and so soon we have the same circumstance in most of country and this works a hardship.

MR. CHAIRMAN: This one purse, how would you encourage private practice in the smaller centres? The Toronto area appears to be taken care of.

MR. FRANK: Yes, well, in our brief we have suggested that aid be given financial assistance through the medium of small interest loans and increased professionals are attracted from the practising physicians in the area. There are two methods of encouragement.

MR. CHALLIES: What do you mean by the second part, making the people aware where you are and what you are doing?

MR. FRANK: It is a question of awareness

mention wage scales? As far as hospital work is concerned the average hospital employee, a physiotherapist is paid in the neighbourhood of approximately --- well, in Hamilton I am quoting here St. Joseph's Hospital, the salary there would run around $365.00 a month. You can figure that out for yourself.

THE CHAIRMAN: $4,200.00 and some odd dollars.

MISS FAGAN: It is not enough for a married man. I do not know how a girl, in fact, could get along with that with the amount of education necessary to equip herself as a physiotherapist, how she could actually be interested in going into institutional work.

THE CHAIRMAN: How does this compare with the nurses' salary in the same institution, a registered nurse?

MISS FAGAN: Practically the same. No, I should correct myself, because actually the present level from my understanding is that the physiotherapist is paid a beginning salary of something like $62.00 a week, which is about the same level as a nurses' aide -- now, that is a nurses' aide, not a nurse.

THE CHAIRMAN: I am talking about the registered nurse.

MISS FAGAN: Well, in Hamilton our nurses have achieved something like $18.00 per day for day duty, that is for the eight hours of day duty.

THE CHAIRMAN: As hospital employees?

MISS FAGAN: Private, they are working in hospital as a private nurse.

position wage are set. As far as hospital work is concerned, the average hospital employee, a physiotherapist is paid in the neighborhood of approximately --- well, in Hamilton I am quoting here St. Joseph's Hospital, the salary there works out around $385.00 a month. You can [illegible]

THE CHAIRMAN: $4,100.00 and some cents difference.

MISS CROWN: It is not enough for a married man. I do not know how a girl, in fact, could get along with that with the amount of education necessary to equip herself as a physiotherapist, how she could actually be interested in going into institutional work. With the nurses' salary in the same institution, a registered nurse?

MISS TAGAN: Exactly the same.

No, I should correct myself, because actually the present level from my understanding is that the physiotherapist is paid a beginning salary of something like $2,[illegible] a week, which is about the same level as a nurses' aide -- no, that is a nurses' aide, not a nurse.

[illegible]

nurses have received something like $11.00 per day for day duty, that is for the eight hours of duty.

[illegible] MR. [illegible]: Anyway, they are working in hospital as a private nurse.

THE CHAIRMAN: I am speaking about employing a registered nurse, one who is employed as a ward nurse.

MISS FAGAN: You mean a general duty nurse?

THE CHAIRMAN: Yes?

MISS FAGAN: They do not receive the same level from my understanding --- after all, I am a physiotherapist, I am not really quite as acquainted with their level. In other words, I am quoting from memory of what I have read in the Hamilton Spectator and actually the level of your private duty nurse working in hospital is higher than your general duty nurse.

THE CHAIRMAN: What I was merely trying to get at was a comparative figure for the two employees in the same institution.

MISS FAGAN: Well, I could not actually say, Mr. Chairman, exactly what the general duty nurse would get because actually most of your nurses working in hospitals today are on a private nurse basis.

THE CHAIRMAN: I will not pursue it, but I could not accept that as being the fact. We know that hospitals are employing hundreds of general duty nurses and I think Miss Girard would bear that out.

COMMISSIONER GIRARD: There are more general duty nurses than special nurses and the special nurse is the one that gets the higher salary, because she is on her own, she is like a physiotherapist that is in private practice. However, I believe ---

THE CHAIRMAN: I am speaking about employing a registered nurse, one who is employed as a [illegible] nurse.

MISS PARKS: You mean a general duty nurse?

THE CHAIRMAN: Yes?

MISS PARKS: If you do not receive the same level from my understanding --- after all, I am a occupational therapist, I am not really quite as acquainted with their level. In other words, I am quoting from memory of what I have read in the Hamilton Spectator and actually the level of your private duty nurse working in hospital is higher than your general duty nurse.

THE CHAIRMAN: What I was merely trying to get at was a comparative figure for the two employees in the same institution.

MISS PARKS: Well, I could not actually say, Mr. Chairman, exactly what the general duty nurse would get because totally [illegible] of your nurses working in hospitals today are on a private nurse basis.

THE CHAIRMAN: I will not pursue it, but I could not accept that as being the fact. We know that hospitals are employing numbers of general duty nurses and I think Miss Allard would back that out.

MRS. [illegible]: There are more general duty nurses than special nurses and the special nurse is the one that gets the higher salary, because she is on her own, she is like a physiotherapist that is in private practice. However, I believe ---

THE CHAIRMAN: Perhaps you might give us a comparison, if you are able to give us the figure for the hospital orderly.

MISS FAGAN: No, I can't say that.

THE CHAIRMAN: As a male employee.

MISS FAGAN: Because I would be quoting from probably six or seven years back. I know actually they were paying a little bit more than what the orderlies here at the Toronto General got when they had their strike. That would be about 1938, 1940, I think.

THE CHAIRMAN: I am going to make the same suggestion I made to Miss Macpherson. You heard the discussion here this afternoon, the two previous groups. Have you comments you wish to make on what was said or in relation to the questions which were asked, supplementary information that may have occurred to you that you would be able to help us with.

MR. CLARK: Speaking of physiotherapy aides, the problem of aides in physiotherapy -- you have a problem produced in that the physiotherapy aide is only allowed to do non-technical duties. If the physio could be relieved, as has been suggested, of the non-technical aspect of the work by the introduction of aides in a training program for aides I think this would greatly facilitate the spread of your physiotherapy services in a way to meet actual need rather than in non-technical duties.

In regard to our submission the one thing that I would like to point out is the discrepancy

THE CHAIRMAN: Perhaps you might give us a comparison, if you are able to give us the figure for the hospital orderly.

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In regard to our submission the one thing that I would like to point out is the discrepancy

in the uniformity of municipal zoning by-laws, that is 3(b). This creates a problem for the practising physiotherapists and works a hardship on the patient in that you have in municipal governments umpteen variations of by-laws relating to professional practice. You have everything from the by-law which is comprehensive and includes doctors, dentists or drugless practitioners, of which the physiotherapist is included to by-laws which state doctor and define as physician only. We feel the location of a proper clinic in the residential area is a very necessary entity in the practice of physiotherapy to relieve the burden of people travelling to downtown areas.

COMMISSIONER FIRESTONE: Mr. Clark in paragraph F on page 3 you suggest that in order to encourage private practice in smaller centres subsidies should be provided or low interest loans to private practitioners. What kind of subsidies did you have in mind, sir?

MR. CLARK: Initially it takes three to five years for a private practitioner to establish his clinic and provide the adequate services both from the patient's standpoint and from his standpoint of procuring a living. In that interim period he requires help. There are many physiotherapists in institutional work who are well qualified to carry out the doctor's direction in private practice and could relieve much of the burden on hospitals, but for the initial step of renting or leasing or buying a place and equipping it with modern equipment that will do the

in the minority of municipal zoning by-laws, that is (1). This creates a problem for the practitioner [illegible] and works a hardship on the patient in that you have in municipal governments unless [illegible] relations of by-laws relating to professional practice. You have everything from the by-law which is comprehensive and includes doctors, dentists or drugless practitioners, of which the physiotherapist is included to by-laws which state doctor and define as physician only. As [illegible] the location of a proper clinic in the residential area is a very necessary entity in the practice of physiotherapy to relieve the burden of people travelling [illegible]

CHAIRMAN, MR. [illegible]: Mr. [illegible], on page 2 you suggest that in order to encourage private practice in smaller centres [illegible] should be provided on low interest loans to private practitioners. What kind of subsidies did you have in mind, sir?

MR. [illegible]: Initially it [illegible] three to five years for a private practitioner to establish his office and provide the adequate surroundings from the material standpoint and from his standpoint of producing a living. In that interim period he requires help. We are many physiotherapists [illegible] institutional work who are well qualified to carry on the factors of practice in private practice and could [illegible] of the [illegible] or hospitals, but for the initial step of renting or leasing or buying a place and equipping it with modern equipment that will [illegible] the

job that is expected in physiotherapy today. In the initial period of the first three years he could do with help. We suggest either low interest government loans or some type of subsidization that would get him past that period. He would be required to pay it back. He would be equipped to pay it back.

COMMISSIONER FIRESTONE: He would be required to pay back in the case of a loan. I will come back to the subject of the loans in a minute. I am trying to understand what you mean when you say a subsidy. Did you mean these subsidies, grants given to this person if he settles in one of the smaller centres on the condition that he remains there, is that what you had in mind? Are these tied subsidies?

MR. CLARK: This was done in some parts of the States and I understand quite successfully, where they subsidize for people to go into an area where they hadn't been able to attain professional services.

COMMISSIONER FIRESTONE: I appreciate it might have been done in the States, but I am trying to establish what your recommendation entails if we want to make use of it in Canada. Are you visualizing that a grant be made to this particular person of $2,000.00, $3,000.00 a year to establish himself in that community for a period of three years? What do you have in mind specifically?

MR. CLARK: Specifically you have areas in Ontario where about the only way practical that a physiotherapist could function would be with some type of subsidization either by local government, provincial

job that is apparent in physiotherapy today. In the initial period of the first three years he could go with help. He suggests either low interest government loans or some type of subsidization that would get him past that period. He would be required to pay it back. He would be equipped to pay it back.

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MR. [illegible] Specifically you have areas in Ontario where most the only man or [illegible] that any interested could function would be with some type of subsidization either by local government, providing

grants or federal grants. The services are required. We transport children hundreds of miles to centres here in the city for treatment that they could much better receive at home if the service were available to them.

COMMISSIONER FIRESTONE: I am trying to be practical, assuming there would be smaller hospitals in the smaller centres could that therapist not be put on a salary to provide certain services at that hospital. He might be spending only part time there and that would give him a basic minimum and he would then be permitted to practise outside the hospital if he could find patients and develop a practice. Would that sort of approach meet the point you have in mind when you say subsidy?

MR. CLARK: This is already being done, but we don't think it should be only in isolated cases. I know of one case in Tillsonburg where the physiotherapist does it, part time in the hospital plus a private practice. They have come to terms with the Hospital Services Commission in regard to that service. The same sort of thing could be done elsewhere I feel sure. There should be some publication of the knowledge or standard set, not just leave it to the local level because nobody wants to dig too much.

COMMISSIONER FIRESTONE: How much does it cost to acquire a reasonable amount of equipment for a young person starting out in practice?

MR. CLARK: I would suggest a minimum of $5,000.00, and that would be strictly in equipment. He then has to find a place to put it so that you would

private or federal private. The services are required. We transport children hundreds of miles to centres here in the city for treatment that they could much better receive at home if the service were available to them.

COMMISSIONER LIPSCOMBE: I am trying to be practical, assuming there would be smaller hospitals in the smaller centres could that therapist not be put on a salary to provide certain services at that hospital. He might be spending only part time there and that would give him a basic minimum and he would then be permitted to practise outside the hospital. It he could find patients and develop a practice. Would that sort of approach meet the point you have in mind when you say subsidy?

MR. CLARK: This is already being done, but we don't think it should be only in isolated cases. I know of one case in Thickbung where the physiotherapist does it, part time in the hospital plus a private practice. They have come to terms with the Hospital Services Commission in regard to that service. The same sort of thing could be done elsewhere I feel sure. There should be some publication of the knowledge of arrangements, not just leave it to the local level because nobody wants to dig too much.

COMMISSIONER LIPSCOMBE: How much does it cost to acquire a reasonable amount of equipment for a young person starting out in practice?

MR. CLARK: I would suggest a minimum of $2,000.00, and that would be at latin in equipment. It then has to find a place to set it so that you would

have an outlay of close to $5,000.00 to physically say this is a clinic and start from there.

COMMISSIONER FIRESTONE: Have you had instances where people trying to establish themselves in practice have told you or your associates that they cannot borrow $5,000.00 from the bank and get established in practice? The interest on $5,000.00 would be something like $300.00 a year. Is this a very heavy burden that you feel the government should enter the field when we have financial institutions whose business it is to lend money to professionals and otherwise?

MR. CLARK: The newly graduated physiotherapist has a pretty rough time digging up references to satisfy the bank of his ability to pay. The bank will not take education as collateral for a loan.

COMMISSIONER FIRESTONE: Is it not true that some doctors go to banks to get some help to buy equipment in the initial period?

MR. CLARK: That they do. I did myself.

COMMISSIONER FIRESTONE: And you succeeded?

MR. CLARK: I didn't get $5,000.00. I had to settle for much less, but it was a start. What I am suggesting is I hope that all physiotherapists do not have to start like I did.

COMMISSIONER FIRESTONE: Are you familiar that professional people can go to the Industrial Development Bank and obtain loans for the purchase of equipment?

have an outlay of close to $2,500.00 to physically enter into a clinic and start from there.

CONGRESSMAN FIRESTONE: Have you had instances where people trying to establish themselves in practice have told you or your associates that they cannot borrow $5,000.00 from the bank and get established in practice? The interest on $5,000.00 would be something like $300.00 a year. Is this a very heavy burden that you feel the government should enter the field when we have financial institutions whose business it is to lend money to professionals and otherwise?

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MR. LEAK: That they do. I did myself.

CONGRESSMAN FIRESTONE: And you

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MR. LEAK: I didn't get $5,000.00. I had to settle for much less, but it was a start. What I am suggesting is I know that physiotherapists do not have to start life I did.

CONGRESSMAN FIRESTONE: Are you familiar that professional people can go to the Department of Veterans Affairs and obtain loans for the purchase of equipment?

MR. CLARK: I am not, no.

COMMISSIONER FIRESTONE: May I suggest to you to examine the Act as amended in the last session of Parliament. You will see that professional personnel can now obtain loans under the Act where they demonstrate they could not obtain loans through other channels such as chartered banks. Thank you very much.

THE CHAIRMAN: Thank you very much Mr. Clark.

THE SECRETARY: The next brief, Mr. Chairman, is the Association of Remedial Gymnasts. It will be known as exhibit 317. Mr. Wells will present the submission.

---EXHIBIT NO. 317: Submission of The Association of Remedial Gymnasts (Ontario)

(MR. ISLIONA, PROPOSING: May I suggest [illegible] of Peerla-on. You will see that professional personnel can not obtain loans under the Act where they demonstrate they could not obtain loans through other channels such as chartered banks. Thank you very much.

THE CHAIRMAN: Thank you very much [illegible].

THE CHAIRMAN: The next brief, Mr. Chairman, is the Association of Peerla Communes. It will be known as exhibit 31. Mr. Wells will present [illegible].

---PUBLIC EXHIBIT NO. 31:

Submission of the Association of La Peerla Communes (Ontario)

SUBMISSION OF

THE ASSOCIATION OF REMEDIAL GYMNASTS (ONTARIO)

APPEARANCES: Mr. T.P. Wells
Mr. D.E.Creighton

MR. WELLS: Mr. Chairman and Members of the Royal Commission my colleague is Mr. Dennis Creighton and I am Thomas Percy Wells, President of the Ontario Association of Remedial Gynmasts. In presenting this brief, sir, I would like to say the two of us represent a very small body of men and as such we had to compile this brief ourselves. Unfortunately we had a very short time to do it so I should apologize first of all for a few typographical errors you will find in our brief due to the fact we had a short time for proofreading. I hope, sir, you will forgive it.

We believe, sir, that our presentation will show the role and employment of the specialty of Remedial Gymnasts in recreational therapy and of those who practice it can effectively contribute to the success which today's conception of total rehabilitation lays claim.

It is with this conviction that we present the brief with the sincere hope that the services of the skill and personnel will be made available to all who would benefit from them.

So the conclusions, sir, that we arrived at are as follows:

SUBMISSION OF

THE ASSOCIATION OF REMEDIAL GYMNASTS (ONTARIO)

PRESENTED: Mr. T.P. Wells

Mr. WELLS: Mr. Chairman and Members of the Royal Commission my colleague is Mr. Dennis Creighton and I am Thomas Percy Wells, President of the Ontario Association of Remedial Gymnasts. In presenting this brief, sir, I would like to say the two of us represent a very small body of men and as such we had to compile this brief ourselves. Unfortunately we had a very short time to do it so I should apologize first of all for a few typographical errors you will find in our brief due to the fact we had a short time for proofreading. I hope, sir, you will forgive it.

We believe, sir, that our presentation will show the role and employment of the specialty of Remedial Gymnasts in reconstructional therapy and of those who practice it can effectively contribute to the success which therapy's conception of total rehabilitation lays

It is with this conviction that we present the brief with the sincere hope that the services of the skill and personnel will be made available to all who would benefit from them.

So the continues, sir, that we arrived at one as follows:

/dpw

In convalescent, physical maintenance and restorative phases of care, experience has shown that Remedial Gymnastics and Recreational Therapy can play a major role. This has helped to reduce the stay in hospitals or other institutions and enabled the person to enter into gainful employment more quickly. Also through Recreational Therapy the patient is able to maintain a cheerful outlook and morale. This also helps to shorten the institutional stay.

A recent review has shown that the Remedial Gymnast is best employed in institutions larger than 150-bed capacity. This number enables the gymnast to take the patients in class-form. Also, a number of hospitals who do not employ a Remedial Gymnast at present would do so when their programs are developed.

The retirement age is approaching for ex-service Remedial Physical Training Instructor and Remedial Gymnast necessitating replacement. This can only be done by the inauguration of an educational establishment in Remedial Gymnastics and Recreational Therapy.

A review of the member's "Application for Membership" forms indicated a lack of academic uniformity. For effective communication with the other treatment auxiliaries and also recognition by these people a comparable education standard, leading to an acknowledged certification must be made available.

A large percentage of the public is unaware of the Remedial Gymnast, his training,

qualifications, employment and more importantly the role that he can play in effective rehabilitation.

That the remuneration offered to the present-day Remedial Gymnast is not one which will attract the right type of person who would wish to make this form of vocation a life-time career.

That Remedial Gymnastics and Recreational Therapy do not compete with physiotherapeutic procedures but, supplement them and where there is a team effort, in the true sense, both have their own part to play; the physiotherapist concerned with individually prescribed treatment and the Remedial Gymnast taking over when this phase gives place to class or group activities.

RECOMMENDATIONS

For consideration by the Royal Commission on Health Services, the Association of Remedial Gymnasts (Ontario) recommends that:

The Remedial Gymnast be included in all present and future Health and Medical Care programs where his services are beneficial and contribute to the treatment of the individual and the welfare of the population as a whole.

A course of training in Remedial Gymnastics and Recreational Therapy be established to meet the present and growing demand for trained Remedial Gymnasts. This course should be comparable to The Remedial Gymnast in Great Britain and the Corrective Therapist in the U.S.A.

Assistance be given to the Association

qualifications, employment as a more importantly the role that a career in effective rehabilitation.

That the recuperation offered to the present-day remedial gymnast is not one much will attract the right type of person who would wish to make this form of vocation a life-time career.

That Remedial Gymnastics and Recreational Therapy do not compete with physiotherapeutic procedures but, supplement them and where there is a team effort, in the time course, both have their own part to play, i.e. physiotherapist concerned with medically prescribed treatment and the remedial gymnast taking over when this phase gives place to class or

CONCLUDING

For consideration by the Royal Commission on health services, the Association of Remedial Gymnasts (Ontario) recommends that:

The Remedial Gymnast be included in all present and future health and welfare programs where his services are essential for contribution to the treatment of the individual and the welfare of the population as a whole.

A course of training in Remedial Gymnastics and Recreational Therapy be established to meet the present and future demand for trained personnel.

[illegible] to the [illegible] Department of Health for [illegible] presently employed in the [illegible].

Copies are given to the Association

in developing a program to recruit suitable candidates for training as Remedial Gymnasts. This should be done at high school level through the Vocational Guidance Counsellor.

To attract the right type of candidate into this profession a commensurate level of wages must be received.

The Remedial Gymnast, trained in the specialty of Recreational Therapy, be employed in school and community programs in which prevention of physical and functional deterioration and correctional therapy are included. This health care should be the right of all, especially the youth of the Nation.

These, sir, are our recommendations.

THE CHAIRMAN: Thank you very much, Mr. Wells. You stated at one of the conclusion paragraphs, No. 14, that the remedial gymnast takes over when this phase gives place to class or group activities. What is the average size of the group which you may be concerned with?

MR. WELLS: I speak now, sir, for present-day usage in my own institution, where I employ 13 remedial gymnasts.

THE CHAIRMAN: What institution is that?

MR. WELLS: That is the Workmen's Compensation Board, sir, of Ontario. Our classes range anywhere from 10 to 60. The best number I would imagine for control would be anywhere in the region of 16 to 20.

for training as Remedial Gymnasts. This should be done at high school level through the Vocational Guidance Counsellor.

To attract the right type of candidate into this profession a commensurate level of wages must be received.

The Remedial Gymnast, trained in the speciality of Recreational Therapy, be employed in school and community programs in which prevention of physical and functional deterioration and correctional therapy are involved. Good health care should be the right of all, especially the youth of the Nation.

These, sir, are our recommendations.

THE CHAIRMAN: Thank you very much, Mr. Wells. You stated at one of the conclusion [illegible], No. 14, that the recreational [illegible] takes over [illegible] this phase [illegible] place to cities or group activities. What is the average size of the group which you would be concerned with?

MR. WELLS: I would say, sir, for recreational purposes in my own institution, it is [illegible]

THE CHAIRMAN: What institution is that?

MR. WELLS: That is the Workmen's Compensation Board, sir, of Ontario. Our current [illegible] [illegible]. The [illegible] would [illegible] for control [illegible] ratio of 1 to [illegible].

THE CHAIRMAN: I don't want to put this incorrectly, but do you see yourselves as having any function in the acute hospital?

MR. WELLS: Yes, sir, I was trained in Great Britain, and there I was engaged in the ward, pre-operative and post-operative, sir.

THE CHAIRMAN: Just in what way?

MR. WELLS: For specific exercises, sir, particularly in orthopaedic hospitals.

THE CHAIRMAN: You mention a school program at Recommendation No. 19. What would be the function of the remedial gymnast in a school program?

MR. WELLS: Well, I am thinking more, sir, on the preventive side of physical deterioration. I am thinking in terms - I can remember quite well that I was actively engaged in pre-service training in the old country during the National Service years, sir, and I was stationed at a centre where we had similar conditions prevailing, where we gave pre-service reconditioning programs to sub-standard recruits.

There we dealt with the postural defect, the person who was slightly underweight, who was sub-standard as far as physical standards, sir, and there my job was to, by a process of physical conditioning in a short three months, to improve their physical standards.

I am thinking in terms of a similar capacity now, where the remedial gymnast, whose skill is largely that of adaptive physical education, supervised medically, these people can be usefully employed

[illegible] I don't want to say this incorrectly, but do you see yourselves as having any impact on the asset base?

MR. WILLE: Yes, sir. I was trained in Great Britain, and there I was engaged in the work of co-operative and post-operative, sir.

MR. CARTER: Just in what way?

MR. WILLE: For specific exercises.

MR. CARTER: You mention a medical program in Recommendation No. 19. What would be the function of the remedial gymnast in a school program?

MR. WILLE: Well, I am thinking, more, sir, of the preventive side of physical deterioration. I am thinking in terms - I can remember quite well that I was actively engaged in pre-service training in the air country during the medical service years, sir, and I was stationed at a centre where we had some very conditions prevailing, where we gave pre-service reconditioning programs to ex-servicemen [illegible].

[illegible] the physical [illegible], the person who was slightly underweight, who had anti-tuberculosis or [illegible] conditions, sir, and there my job was to, by a process of physical reconditioning in a short [illegible] months, to increase their physical stamina.

I am talking in terms of a similar situation now, where the medical supervisor, [illegible] is largely that of preventive physical education, [illegible] [illegible], [illegible] can be [illegible]

by municipalities in taking schoolchildren of this particular quality.

THE CHAIRMAN: Are you familiar with the Canadian Association of Health, Physical Education and Recreation?

MR. WELLS: No, sir, I am not.

THE CHAIRMAN: I was wondering just what similarity, or dissimilarities, you might be able to give us, because we heard from them yesterday afternoon in somewhat the same, parallel language and propositions.

MR. WELLS: Well, I feel there is a difference here, sir, that the remedial gymnast is a person who has been medically trained besides having had a basic of the other. I don't know how these other people have been trained, whether they have received further training under medical direction.

THE CHAIRMAN: The remedial gymnast; you say he has been medically trained?

MR. WELLS: Yes, sir.

THE CHAIRMAN: Does he operate under a prescription?

MR. WELLS: Yes, sir. He is an institutional worker primarily. I know of no instance where a remedial gymnast, sir, is employed on a private basis.

THE CHAIRMAN: Do you wish to add something, Mr. Creighton?

MR. CREIGHTON: I don't think I could add anything to that.

THE CHAIRMAN: I thought a while ago

by my principles in talk, accordingly on this particular quality.

Dr. [illegible]: Are you familiar with the American Association of Health, Physical Education and Recreation?

Mr. [illegible]: No, sir, I am not.

What similarity, or dissimilarities, you might be able to give us, because we heard from them yesterday afternoon in somewhat the same, parallel language and [illegible]

Mr. [illegible]: Well, I feel there is a difference here, sir, that the medical examiner is a person who has been medically trained besides having had a basic of the course. I don't know how these other people have been trained, whether they have received [illegible]

The CHAIRMAN: The medical examiner, you say he has been medically trained?

Mr. [illegible]: Does he operate under a [illegible]

Mr. WHITE: Yes, sir. He is an institutional worker medically. I know of no instance where a medical examiner, sir, is employed on a private basis.

The CHAIRMAN: Do you wish to add something, Mr. Creighton?

Mr. CREIGHTON: I don't think I could add anything to that.

The CHAIRMAN: I thought a while ago

that you were indicating that you might have something to add?

MR. CREIGHTON: I was thinking on the educational aspect, that we had a course in mind that we had more or less designed. This course; we don't know of any in Canada and we would like to see a course established.

THE CHAIRMAN: That is a course of what?

MR. CREIGHTON: A course in remedial gymnastics and recreational therapy, both. There is a course ---

THE CHAIRMAN: In terms of physical education; is it along the same lines?

MR. CREIGHTON: There would be a similarity, yes, but the remedial gymnast would go along on the medical aspect of this, the treatment of medical problems, where the physical educationist is primarily concerned with the schoolchildren and he is not concerned with any physical deformities, or anything of this nature.

THE CHAIRMAN: How would you go along then on the medical side?

MR. CREIGHTON: Well, just what do you mean by ---

THE CHAIRMAN: Well, you just said that you are concerned with the medical aspect.

MR. CREIGHTON: Well, the remedial gymnast has studied the medical conditions, and he applies his knowledge to these medical problems that

that you were thinking that you might have something to add.

Mr. CREIGHTON. I was thinking on the support and assist, that we had a course in mind that we had gone on less designed. This course; we don't know of any in Canada and we would like to see a course established.

The CHAIRMAN: That is a course of what?

Mr. CREIGHTON: A course in remedial gymnastics and occupational therapy, both. There is a course ---

The CHAIRMAN: In terms of physical education; is it a -- the same lines?

Mr. CREIGHTON: There would be a similar by, yes, but the remedial gymnast would go along on the medical aspect of this, the treatment of medical problems, where the physical education is primarily concerned with the adolescent then and be in not concerned with the medical therapeutic, or anything of this nature.

The CHAIRMAN: Do you wish to state that in the record?

Mr. CREIGHTON: Yes, you just said that we are concerned with the medical aspect.

Mr. CHAIRMAN: Well, the training gymnast is the medical conditions, can be qualified by knowledge to treat reduced processes that

arise. Orthopaedic cases, geriatric cases.

Then there is also the pre-operative and the post-operative patient, that this remedial gymnast would condition the person prior to a specific operation, usually again in an orthopaedic capacity.

MR. WELLS: I think the term, sir, adaptive physical education expresses just what Mr. Creighton really means here. It is exercise adapted to a medical end, and it is supervised very, very religiously by the medical man, whom you cannot work without.

COMMISSIONER GIRARD: Mr. Chairman, I was just wondering, you said there were no schools here in Canada for remedial gymnasts?

MR. WELLS: That is right.

COMMISSIONER GIRARD: Did both of you train abroad in some other country?

MR. WELLS: I was sent to Canada in 1943 as a member of the British team of Army Physical Training Corps, and when I came to Canada I had to train selected officers, warrant officers and N.C.O.'s, to start the casualty re-training centres that were being introduced at that time to deal with the Canadian casualties.

After the war I was retained here in Canada for a further year by the Department of Veterans' Affairs, and I was responsible there, under the direction of the Director of Physical Medicine in Ottawa, training another four courses, approximately 200 men, in adaptive physical education to staff the D.V.A. hospitals across

Daughter

Then there is also the pre-operative and the post-operative patient, that this remedial measure works condition the person prior to a surgical operation, usually again in an orthopedic capacity.

MR. WILES: I think the term, sir, corrective physical education expresses just what he [illegible] really means here. It is exercises are too medical and it is supervised very, very religiously by the medical man, whom you cannot work

[illegible]

Was just wondering, you said there were no schools [illegible] in Canada for medical graduates?

MR. WILES: That is right.

QUESTION BY DOUG GIVENS: [illegible] of you training teachers in some other country?

MR. WILES: I was sent to Canada in 1945 as a member of the building team of Army Education Corps, and when I came to Canada I had to train several officers, warrant officers and [illegible], to start the country re-training [illegible] for [illegible] interested at that time to [illegible] the [illegible] [illegible].

After the war I was [illegible] [illegible] for a further year [illegible] [illegible], and I was [illegible] [illegible] [illegible] of the director of [illegible] training in [illegible], training [illegible] our country, [illegible] [illegible], [illegible] [illegible] [illegible] to [illegible] [illegible] [illegible]

the Dominion.

Since then, madam, there has been no training at all in remedial gymnastics. The people I am able to recruit are other physical educationists, and we do training on the job.

COMMISSIONER GIRARD: In-service training?

MR. WELLS: Yes.

COMMISSIONER GIRARD: So that all those that have been trained have been trained on the job?

MR. WELLS: Yes.

COMMISSIONER GIRARD: What would be your curriculum if you did have a school? Would this be a one-year course, a two-year course?

MR. WELLS: No, I was thinking about a very similar plan that prevails in our nursing schools. I was thinking it is part technical and it is part academic.

COMMISSIONER GIRARD: Would you be the equivalent of nursing assistants in a nursing school?

MR. WELLS: No, not at all.

COMMISSIONER GIRARD: What would be your position?

MR. WELLS: Let me say that I feel it could be based upon a hospital, and the technical training could be taken from a hospital that employs a specialist in physical medicine, and then the academic, I feel, should be comparable to the combined P.T.O.T. that is now being carried out on a similar plan, and

the Dominion.

Since then, madam, there has been no training at all in remedial gymnastics. The people I am able to recruit are other physical educationists, and we do training on the job.

COMMISSIONER GRANT: So that all those that have been trained have been trained on the job?

(Question not heard): What would be your conclusion if you did have a school? Would it be a one-year course, a two-year course?

Mr. WELLS: Oh, I was thinking about a very similar plan that presents in our nursing schools. I was thinking in part technical and in part

COMMISSIONER GRANT: Would you be the equivalent of nursing assistants in a nursing school?

Mr. WELLS: No, not at all.

COMMISSIONER GRANT: What would be your position?

Mr. WELLS: Let me say that I feel it could be based upon a hospital, and the technical training would be taken from a hospital that employs a specialist in physical medicine, and then the practical, I mean, should be connected to the courses P.T.A.A. that is now being carried out on a similar plan, and

therefore, at the end of two years, I would suggest that a further year of internship on a negotiated wage basis for a further year under training in a general hospital, a neurological unit, a geriatric unit, and other units similar to that.

Now, this would lead to a three-year diploma course, at the end of which a diploma granted by a centre of higher education.

I don't see this being on the same level as a nursing aide. I see it on the same level as the P.T. or the O.T., for these are the people we have to work with.

COMMISSIONER GIRARD: Well, why wouldn't your school be in those schools, or departments of those schools, since there is a great relationship in the functions?

MR. WELLS: This would have to be negotiated, and I would think we haven't arrived at that as an Association. We have not come to that level of negotiation. Immediately our brief has been accepted, or refused, here, we hope to get our Charter on the ---

THE CHAIRMAN: It is not a case of either being accepted or refused, Mr. Wells. We receive it as information, as the considered views of you gentlemen who are knowledgeable in this field and it will become part and parcel of the whole information that we have gathered together to use as our judgment makes it fit ultimately, but as of now we don't reject it, because we have received you.

[illegible] and of two years, I would suggest that a further year of internship on a negotiated basis for a fourth year under training in a general hospital, a neurological unit, a geriatric unit, and [illegible]

[illegible] at the end of which a diploma granted by a centre of higher education.

I don't see this being on the same level as a nursing aide. I see it on the same level as the L.T. or the R.N., for these are the people we have to work with.

[illegible] (CASS): Well, why wouldn't your school be in those schools, as departments of those schools, since there is a great relationship in the nursing?

[illegible]: This would have to be negotiated, and I would think we haven't arrived at that as an association. We have not come to that level of negotiation. Already only our brief has been accepted, or rejected, here, we hope to get our [illegible] on the ---

[illegible]: It is not a question of other items accepted or rejected, [illegible] it is information, [illegible] understanding the nurse's predicament in this field and it will [illegible] part and parcel of the nurse [illegible] that we have entitled together to use as [illegible] cause in fact ultimately, but as of now we don't [illegible] it, because we have reviews [illegible].

We are grateful to you for having brought it.

MR. WELLS: May I carry on, sir, from there?

THE CHAIRMAN: Yes.

MR. WELLS: Thank you very much; and then I foresee, madam, that since we have finished with the Royal Commission we hope to get the Charter and from there it is our hope, as an Association, to go to the three universities; we are thinking in terms of the U. of T., the York and Queen's and we hope there to enter into the field of negotiation with the Deans, to see about this education, to see if it is possible that they will receive us.

We are grateful to you for having

there?

MR. WILLS: Thank you very much, and

thank Congress, madam, that since we have finished with the Royal Commission we hope to get the Charter and from there it is our hope, as an Association, to go to the three universities; we are thinking in terms of the U. of ..., New York and Queen's and we hope there to enter into the field of negotiation with the Deans, to see how this education, to see if it is possible that they will receive us.

BL/ss

COMMISSIONER FIRESTONE: Mr. Wells, in Paragraph 83 you suggest that in the course established for remedial gymnasts there also be established an employment bureau to list the employment outlets for those who graduate. Where do you visualize such an employment bureau to be established? Do you feel that the National Employment Service could perform that function?

MR. WELLS: No, I do not. I feel that the Association, the Remedial Gymnasts in particular, is very little known; in fact, we had a questionnaire which we sent out to all the institutions across the Province; I think we sent somewhere around 105, or so, I am not sure of the figure at the moment according to memory. But of those we only received about 60 replies. So we are not widely known, and many people from day to day will ask: "What are you? Who do you represent? Are you conflicting at all with the physiotherapists or the occupational therapists?" So it is with this in mind I feel it is no use in thinking of terms of training if there are no employment outlets. We are a very small body. I think the term of employment bureau here will be coupled with the academic institutions where they could run an outlet.

COMMISSIONER FIRESTONE: If I understood you correctly, you are visualizing these courses to be given at the University; is that right?

MR. WELLS: Part university but based on the hospital.

COMMISSIONER FIRESTONE: Part in a

In Lansdown do you suggest that in the courses established for remedial gymnasts there also be established an employment bureau to list the employment outlets for those who graduate. Where do you visualize such an employment bureau to be established? Do you feel that the National Employment Service could perform that?

MR. WILLIS: No, I do not. I feel that the Association, the Remedial Gymnasts in particular, is very little known; in fact, we had a questionnaire which we sent out to all the institutions across the Province; I think we sent somewhere around 105, or so, I am not sure of the figure at the moment according to memory. Out of those we only received about 60 replies. So we are not widely known, and many people from day to day will ask: "What are you? Who do you represent? Are you conditioning at all with the physiotherapists or the occupational therapists?" So it is quite true in mind I feel it is no use in thinking of terms of training if there are no employment outlets. We are a very small body. I think the term of employment bureau here will be coupled with the academic institutions where they could run an outlet.

CHAIRMAN: PRAT 101: If I understood you correctly, you are visualizing these courses to be given at the University; is that right?

MR. WILLIS: Just underneath our broad roof, I suppose.

CHAIRMAN PRATT: Just in a

university and part in a hospital.

MR. WELLS: That is right.

COMMISSIONER FIRESTONE: And then there would be an employment bureau attached to which institution?

MR. WELLS: I think in university institutions.

COMMISSIONER FIRESTONE: And you visualize an employment bureau specializing only for remedial gymnasts?

MR. WELLS: Yes, I do, to give you a direct answer, but I don't think -- it would have to be not more than a very perfunctory one.

COMMISSIONER BALTZAN: Mr. Wells, how does your scheme fit into the current physical fitness program? I am just trying to learn where you come in.

MR. WELLS: Yes. I feel that in any physical fitness program there is a direct and indirect method of reconditioning. I think the direct is concerned with the well person who merely wants physical maintenance. There are others who can do very well on a program of adaptation. For instance, I have been concerned with the March of Dimes quite recently in Brockville. We have in Brockville a community project fostered by the rehabilitation foundation in which a considerable number of handicapped people have been vocationally rehabilitated, and by lack of facilities and advice these people may be deconditioned and become once again an expense to the community. My job as a remedial gymnast was to go down there and demonstrate how it is possible to maintain a

university and part in a hospital.

COMMISSIONER FIRESTONE: And then there would be an employment bureau attached to which institutions.

MR. WEBBS: I think in university institutions.

COMMISSIONER FIRESTONE: And you visualize an employment bureau specializing only for remedial gymnasts?

MR. MILLS: Yes, I do, to give you a direct answer, but I don't think -- it would have to be not more than a very preliminary one.

Does your scheme fit into the current physical fitness program? I am just trying to learn where you come in.

MR. MILLS: Yes. I see that in any physical fitness program there is a direct and indirect method of reconditioning. I think the direct is concerned with the well person who merely wants physical maintenance. There are others who can do very well on a program of education. For instance, I have been concerned with the work of Pines quite recently in Brockville. We have in Brockville a community project fostered by the rehabilitation foundation in which a considerable number of handicapped people have been vocationally reconditioned by dint of facilities and advice these people have been reconditioned and become an asset to the community. We see a remedial program as to get them back and demonstrate how it is possible to maintain a

level of physical fitness so that they can be independent of others and carry on a living.

COMMISSIONER BALTZAN: Do you do group treatments or individual treatments?

MR. WELLS: Group, sir; although we are qualified to treat individually, sir.

COMMISSIONER BALTZAN: Do you do private practice?

MR. WELLS: No, sir.

COMMISSIONER BALTZAN: In what way do you work? Do you work for organizations?

MR. WELLS: Yes, I work for the Workmen's Compensation Board of Ontario.

COMMISIONER BALTZAN: Lastly, I didn't follow the conversation, I think, you say here in 26 that "several institutions have accepted graduates from the 'College of Massage and Hydro-Therapy' in Toronto."

MR. WELLS: Yes.

COMMISSIONER BALTZAN: There is a school in Toronto?

MR. WELLS: Yes, sir.

COMMISSIONER BALTZAN: I don't want to go into any great details.

MR. WELLS: Yes, there is one that is south of St. Clair on Yonge Street, on Farnham Avenue, and their people are primarily concerned, being taught the rudiments of massage. People go to health clubs, physical centres, and this the only place where you can get men who have a basic knowledge of anatomy, and so on.

COMMISSIONER BALTZAN: It would be

[illegible] [illegible]

of others are carry on a living.

COMMISSIONER BAILIAN: Do you do group therapy or individual treatments?

MR. WELLS: Group, sir; although we are qualified to treat individually, sir.

COMMISSIONER BAILIAN: Do you do private practice?

MR. WELLS: No, sir.

COMMISSIONER BAILIAN: In what way do you work? Do you work for organizations?

MR. WELLS: [illegible]

Man's Condemnation Board of Ontario.

[illegible]

Follow the conversation, I think, you say here in Ontario several institutions have accepted graduates from the College of Massage and Hydro-Therapy in Toronto."

MR. WELLS: Yes.

COMMISSIONER BAILIAN: There is a school in Toronto?

MR. WELLS: Yes, sir.

[illegible]

Do they do any good work?

MR. WELLS: Yes, there is one that is [illegible] and their people are primarily concerned, really taught the principles of massage. People go to health clubs, physical centres, and it is the only place where you can get men who have a basic knowledge of anatomy, and so on.

COMMISSIONER BAILIAN: It would be

possible to supply some information about that school?

MR. WELLS: Yes, sir. I have it here.

COMMISSIONER BALTZAN: And you will do so through the Secretary?

MR. WELLS: Yes.

COMMISSIONER BALTZAN: And you practice under the Drugless Practitioners' Act?

MR. WELLS: No, sir, we do not. That is the man who is trained at this particular college, and he is primarily trained to practice massage and hydro-therapy under the Drugless Practitioners' Act, sir.

THE CHAIRMAN: Thank you very much, Mr. Wells, and Mr. Creighton.

MR. WELLS: Thank you, sir.

THE SECRETARY: Mr. Chairman, the next submission is the Zifkin Biological Laboratory Limited, and Mr.Zifkin will present the submission. It will be known as Exhibit 318.

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provide to supply some information about that annual?

MR. WILLIS: Yes, sir. I have it here.

COMMISSIONER SAULSAW: And you will do so through the Secretary?

MR. WILLIS: Yes.

COMMISSIONER SAULSAW: And you practice under the Oregon Chiropractors' Act?

MR. WILLIS: No, sir, we do not. That is the man who is teaching at this particular college, and he is privately trained to practice massage and hydrotherapy under the Oregon Practitioners' Act, sir.

MR. CHAIRMAN: Thank you very much, Mr. Wells, and Mr. Creighton.

MR. WILLIS: Thank you, sir.

Submission is the Nikkin Biological Laboratory limited, and Mr. Nikkin will present the submission. It will be known as Exhibit 218.

---EXHIBIT NO. 318: Submission of the Zifkin Biological Laboratory Limited.

S U B M I S S I O N O F

THE ZIFKIN BIOLOGICAL LABORATORY LIMITED

APPEARANCES:

MR. H. ZIFKIN

MR. ZIFKIN: I would like to preface my remarks by expressing my appreciation for the privilege of coming here and to expound on my convictions, which have been held over a number of years.

I would like also to express my pride at our Provincial Laboratories and their methods which are under the direction of Dr. Alperton. Also during the brief a mention was made of a home-care plan, and I would express my admiration of Dr. Pachineau and his wonderful group who are experimenting in this particular project.

I have been in the laboratory field now for close on to thirty years as a technician, registered in the Canadian Society of Technologists.

As the years have passed and the technical field has become more complex, I have felt that perhaps people in technology are today a field unto themselves, in a field where they can stand on their own abilities and direction and be able to perform tests on their own. There is an area now where there is a certain amount of confusion. There will be, I am certain, more and

EXHIBIT No. 1: Submission of the Atkin Metrological Laboratory Laboratory.

S U B M I S S I O N O F

MR. H. ATKIN

MR. ATKIN: I would like to preface my remarks by expressing my appreciation for the privilege of coming here and to account on my condition. Have been held over a number of years.

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I have been in the laboratory field for close on to thirty years as a technician, regi in the American Society of Technologists.

As the years have passed on the technical field has become more complex, I am a fair e case been e in technicians are today a field with [illegible] [illegible], in a field where they can stand on their [illegible] [illegible] and direction and be able to [illegible] [illegible] [illegible]. There is an area [illegible] there is a [illegible] [illegible] of [illegible]. There [illegible], I am [illegible]

more laboratories entering the field. Who are to run these laboratories will be, I am afraid, a problem that will have to be faced. Certainly I would not like to degrade the pathologist where he has to do the analysis, although that is what we must expect today under the present system. There should be in my opinion, on the other hand, a method of licensing laboratories in order that they should follow certain standards, approved standards by regulatory bodies.

The technicality of supervision of medicine is a very interesting thing, because I do not feel that it is at all possible any more, as it was when I first washed my first glasses, to see an actual pathologist doing the work in the lab, it has been gradually changed and these things are taking place. I remember my uncle's old Dodge touring car had to be repaired by a civil engineer, and as cars became more popular the civil engineers became more few and we developed mechanics. The optical men, the optometrists, used to grind their own lenses until the technicians took them over. And we have this spreading into the field of dental work where the dental technician is now an entity unto himself.

Now, that is also the privilege of the physician, and this is where the point of technicality comes in. When a physician prescribes a certain lab test, if he asks for a specific thing to be done, does this constitute in itself permission given to a technician in a private laboratory -- by the way, I don't come to ask for any funds; I don't think I could here. However, if this physician prescribes a white count, naming the

more laboratories entering the field. We are to say these laboratories will be, I am afraid, a problem that will have to be faced. Certainly I would not like to compare the pathologist where he has to do the analysis, although that is what we must expect today under the present system. There should be in my opinion, on the other hand, a method of licensing laboratories in order that they should follow certain standards, approved standards by regulatory bodies.

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Now, that is also the privilege of the physician, and this is where the point of technicity comes in. When a professional provides a service for which he has to be a scientific thing to be done, when he constructs in fact, perhaps even even to a far middle in a private laboratory -- by the way, I don't come to see any trouble: I don't think I could have. However, it this position presupposes a white coat, making the

laboratory, does this constitute an actual direction to do a white count on an individual? This is a matter of great debate. There are many things in our laboratory, of course, which are not done because it is unethical to do it, and the matter of morals, ethics, integrity, is not confined to any individual group. But, of course, throughout this broad field of medicine applies to all as one great team.

So we must face the future with a method of grading, licensing, controlling laboratories, but if we are going to license these laboratories the person who is licensed has a responsibility to the licensing group. On the other hand, another interesting development must take place if labs are to be licensed, and that is the next step. If this licensed lab does exist, will it be acceptable to all branches of medicine after that? And I have specific problems here. For instance, if this process of laboratories exists and we are permitted to function, what happens under P.S.I., the Physicians' Services Incorporated or the Associated Medical Services? Will they recognize a request to a physician to our lab and will they honour that fee that will be presented by a lab? We had a pathologist to whom we had given free rental space, performed a test and he did everything himself, submitted his bill to one of the groups here and he was refused payment. The technicality was that he didn't pay rent in our place, although we gave him all the facilities. We found that in that particular case it was not successful. I am sorry to say that two months' work went for naught over a small

laboratory, does this constitute an actual diversion to do a write-up on an individual? This is a matter of great debate. There are many things in our laboratory, of course, which are not done because it is unethical to do it, and the matter of morals, ethics, integrity, is not confined to any individual group. But, of course, throughout this broad field of medicine applies to all as one great team.

So we must face the future with a method of grading, licensing, controlling laboratories, but if we are going to license these laboratories the person who is licensed has a responsibility to the licensing group. On the other hand, another interesting development may take place if labs are to be licensed, and that is the next step. If this licensed lab does exist, will it be acceptable to all branches of medicine after that? And I have specific problems here. For instance, if this process of laboratories exists and we are permitted to function, what happens when F.S.L., the Physicians' Services Incorporated or the Associated Medical Services? Will they recognize a request from physician to our lab and will they honour that and it will be presented to a lab? Is that a safeguard to a man who had given free medical care, performed a test and did everything himself, submitted his bill to one of our groups here and he was refused payment. The reasonability was that he didn't pay rent in our lab, although he gave his all the facilities. He turns that in to a physician case if we are not successful. I am sorry to say that the doctors' work went for weight over a small

technicality, although he was assured payment in all these fields, and the mere fact that he wasn't asked for rent was the excuse. If we are to be licensed here and we are to be accepted, therefore, it is to be established that the one who licenses labs must make it clear that labs have the privilege as all other groups.

This brings in one more fact in relationship to this recognition of labs being limited to one or will there be permission for groups or chains of labs to be functioning under one name. Such a problem, of course, exists with pharmacies. And now, with pharmacies, are they permitted to carry out tests, will they be permitted? We know in many cases they do; we are on a very fine level with the drug stores and pharmacists and we work together. When a doctor hands his specimen to them to be done they are not capable of doing it and they send it over to our lab. On the other hand, many, I am certain, are not at all capable in doing such tests, notwithstanding, they are undertaking to do this particular work. This is something that is gaining great momentum in this city, particularly where drug stores are doing more and more of body fluid testing.

The reason I mention the series of labs is for the sake of economy. For instance, we have two locations now and a third and it is very important in what my own concept of medicine in the future will be. This is another wing that I want to go into, the pilot home care plan.

I think you have my brief here where we mention this home care. This is a matter that we feel many patients, and having been a coronary patient myself, and having been in hospital for many, many weeks and lie in bed waiting for a prothrombine to be done once a day prompted me to go into home service for prothrombine examinations. Previous to that I did

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The reason I mention the series of labs is for the sake of economy. For instance, we have two locations now and a third and it is very important in what my own concept of medicine in the future will be. This is another wing that I want to go into, the point here came plain.

I think you have my brief here where we mention this home care. This is a matter that we feel many patients, and having been a convalescent myself, and having been in hospital for many, many weeks and lie in bed waiting for a physiotherapist to be home once a day prompted me to go into home service for physiotherapy examinations. Previous to that I did

not want to carry out this service but now we do have a system as a result of my own personal experience where instead of a patient being in hospital, once a physician feels he is capable of going home and this test can be done at home as well as many other tests and the patient can go home. The patient could stay for one particular thing and yet a hospital commission pays out the minimum of $20.00 per day and such a test can be done for between $4.00 and $5.00. We have worked with Dr. Pequenat on his plan and it has shown some wonderful results but this plan requires more publicity than it has ever had. We feel the Hospital Commission should undertake perhaps once this pilot plan is well established to investigate perhaps the possiblity of doing more home service laboratory, physiotherapy work in physicians' offices by having more than one lab where from the centre of one particular place you can send out technicians to various parts of the city and take the work back to a centralized lab. In that way you could make things as economical as possible and would cover a large area of the city. This would be the same as they have in Detroit under an experimental planhas cut the hospital stay from 47 to 20 under certain conditions. It is quite possible to see that such a house plan, a home plan could be instituted from the hospital. In other words, to go to the hospital before, to do the work in the home before hospitalization is necessary. This has been carried out in a few countries in the world. By this method private labs could do this better than the hospital for a very interesting reason, that a hospital,

not want to carry out this service but now we do have a system as a result of my own personal experience where insured of a patient being in hospital, once a physician feels he is capable of going home and this test can be done at home as well as many other tests and the patient can go home. The patient could stay for one particular thing and yet a hospital commission pays out the minimum of $20.00 per day and such a test can be done for between $4.00 and $5.00. We have worked with Dr. Fenwick on his plan and it has shown some wonderful results but this plan requires more publicity than it has ever had. We feel the Hospital Commission should initiate perhaps once this pilot plan is well established to investigate perhaps the possibility of doing more home service laboratory, physiotherapy work in physicians offices by having more than one lab where from the centre of one particular place you can send out technicians to various parts of the city and take the work back to a centralized lab. In that way you could make things as economical as possible and would cover a large area of the city. This would be the same as they have in Detroit under an experimental plan for out the hospital stay from 47 to 10 under certain conditions. It is quite possible to see that such a home plan, a home plan could be instituted from the hospital. In order words, to go to the hospital before, to do the work in the home before hospitalization is necessary. This has been carried out in a few countries in the world. By this method private lab could do this better than the hospital for a very interesting reason, that a technical,

usually patients go to that hospital from all parts of the city and they find it uneconomical to do these tests on their discharged patients because they have to cover the whole city. It would be ridiculous actually for a patient from Humber Memorial Hospital who resides in East York and one patient in the area of Scarborough General who decides to go to the Humber Memorial Hospital to have to carry out all this criss-crossing of the way across the city to do one test. We are able to send out technicians in groups and in certain areas and cover the west and the east and the north and go back in a certain time area to intercept them at a certain home because there is a time limit on the keeping of the blood. We could intercept them and bring the work back to the lab and the technician carry on and go to the homes and continue on.

There is nothing really that I have here to ask except the cautioning of the drug stores. I would appreciate in the future the recognition of medical technical labs able to stand on their own feet with a dignity to become one in the lab field and being called medical technologists exactly as they mean.

I would also urge actually the establishing of a licensing system for these labs and to assure every doctor that the labs are qualified and to publicize this.

Also, one thing we have found and, naturally, this becomes an economic thing and I admit it as for us that we feel that the choice of a laboratory should now be placed in the same category as the choice

usually patients go to that hospital from all parts of the city and they find it uneconomical to do tests on their discharged patients because they have to cover the whole city. It would be ridiculous actually for a patient from Number Memorial Hospital who resides in East York and one patient in the area of Scarborough [illegible] to do tests [illegible] the Number Memorial [illegible] to have to carry out all this cross-crossing of the city across the city to do one test. We are able to send out technicians in groups and in certain areas and cover the west and the east and the north and go back in a certain time area to intercept them at a certain time because there is a time limit on the keeping of the blood. We could intercept them and bring the work back to the lab and the technician carry on and go to the lower and continue on.

There is nothing really that I have here to say except the continuing of the drug series. I would appreciate in the future the recognition of medical technicians who [illegible] to stand on their own feet with a dignity to become one in the lab field and being called medical technologists correctly as they really. I would also like to see [illegible] the establishing of a licensing system for these labs and to assure every doctor that the labs are qualified and to publicize this.

Also, one thing we have found and, [illegible], this becomes an economic thing and I admit it, so long as that we feel that the choice of a laboratory should not be placed in the same category as the choice

of a pharmacist, that no physician should authorize or ethically prescribe a definite drug store where a patient should go. We feel that laboratories, and a glance at the yellow pages of our telephone book will show a great number of laboratories in this city, that it should be a privilege of the patient to go to any lab he wishes. I do not think the doctor should say to which lab he should go.

There is the answer, of course, that you do not do this work. Naturally this would limit immediately the recommendation of the doctor to our lab or the patient coming to our lab with a specific thing which we do not do.

I would just conclude with once again asking a greater publicity, a greater encouragement to the home, the private home care plan which is sponsored by the City of Toronto. Thank you very much.

THE CHAIRMAN: Thank you Mr. Zifkin. I must say we are obliged to you for having accepted our invitation to come today instead of as originally planned. Is there any impediment to anyone going into the business of a laboratory?

MR. ZIFKIN: At the moment there is none whatsoever.

COMMISSIONER McCUTCHEON: Is that not the reason why the doctors today must direct people to a particular laboratory because he will at least have some basis of judging the quality of the work and the technical efficiency whereas the patient would not have any?

of a prescribed, that no physician should authorize or ethically prescribe a definite [illegible] where a patient should go. We need that laboratories, and a glance at the yellow pages of our telephone book will show a great number of laboratories in this city, that it should be a privilege of the patient to go to any lab he wishes. I do not think the doctor should say to which lab he should go.

There is the answer, of course, that you do not do this work. Naturally this would limit immediately the recommendation of the doctor to one lab or the patient confine to one lab with a specific [illegible] which we do not do.

I would that our [illegible] with some [illegible] making a greater publicity, a greater [illegible] to the home, the private home care plan which is sponsored by the City of Toronto. Thank you very much.

THE CHAIRMAN: Mean you [illegible], Mr. [illegible]. I must say we are obliged to you for having accepted our invitation to come today instead of [illegible] yesterday. Is there any impediment to answer [illegible] the language of a [illegible]?

MR. MCPEAK: [illegible] the answer there is [illegible] one [illegible].

[illegible]

the reason why the doctor [illegible] must direct people to a particular laboratory [illegible] is [illegible] [illegible] of taking the [illegible] of the work [illegible] [illegible] clerk whereas the doctor would [illegible] [illegible]?

MR. ZIFKIN: On the other hand, I am to be considered too, therefore, I must be inferior.

COMMISSIONER McCUTCHEON: Some doctors may think you are inferior.

MR. ZIFKIN: Yes, that is true, of course, but on the simplest of tests we are capable of carrying it out. I am speaking of the simple things that I have mentioned.

THE CHAIRMAN: You liken yourself to a druggist, a druggist is licensed and can practise only if he is a holder of a licence valid in the province where he is doing business. You say anyone can open a lab and say "Here, I have opened my lab, now everybody must accept me as being as good as Mr. Zifkin merely because I have opened the lab".

MR. ZIFKIN: Excuse me, perhaps I did not make it clear. There is no licensing as such but there is a standard body and a standard of examinations nationally known as the Society of Laboratory Technologists. There is a registry of people qualified to do this particular type of work and even in this organization there are now as many specialists as there are in the field of medicine.

THE CHAIRMAN: Well, a person who has technical qualifications to do laboratory examinations and so forth opens his lab; how does the public get to him at all, just by advertising as you would if you were opening a corner drug store?

MR. ZIFKIN: There has been no advertising to the public at all.

MR. STERN: On the other hand, I do
to be considered too, therefore, I must be interest.

CHAIRMAN MCCULLOCH: Some witness
may think you are interest.

MR. HIRSCH: Yes, that is true, of
course, but on the strength of tests we are capable o
carrying it out. I am speaking of the stress tains
that I have mentioned.

CHAIRMAN: You listen yourself
to a charger, a connect is likewise in can practice
only if he is a holder of a licence valid in the province
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that about me as being as good as it. Within reasonable
reasons I have opened the lab".

MR. HIRSCH: Excuse me, when I
did not make it clear. There is no licensing as such
but there is a standard body and a standard of accredit-
ions nationally known as the society of laboratory
technologists. There is a reality of regular auditing
to do this on a regular type of work and even in this
organization there are not as many specialists as there
are in the field of work.

MR. CHAIRMAN: Well, a person who has
professional qualifications to do laboratory examination
and to work opens his lab; how does the public know
to him, at all, that by examining as to would it can
make condition a better test?

MR. HIRSCH: Anyone can report to
to the public at all.

THE CHAIRMAN: Or to the profession?

MR. ZIFKIN: To the profession and never by a personal visit in all my 30 years.

THE CHAIRMAN: Well, to the available market?

MR. ZIFKIN: Yes, it has always been by mail and all just goodwill. In hospitals we are now finding our services are being used in the smaller hospitals ---

THE CHAIRMAN: Those which do not maintain a full scale laboratory?

MR. ZIFKIN: No but neither do we.

THE CHAIRMAN: If hospitals do not have this then you provide the service?

MR. ZIFKIN: Yes.

COMMISSIONER BALTZAN: I think I saw it here where you mention that there is a provincial laboratory in Ontario and that is located where?

MR. ZIFKIN: We have a very wonderful system of laboratories here. We have a main laboratory on Christie Street in Toronto and I think there is anticipated a very large new one being built on the outskirts of the city. There are, I think, something like seven or eight branches throughout the province.

COMMISSIONER BALTZAN: Those are provincial laboratories?

MR. ZIFKIN: Yes.

COMMISSIONER BALTZAN: And they supply that service of specimens to be examined?

MR. ZIFKIN: Basically they are public

THE CHAIRMAN: On to the professional?

MR. ZIFKIN: To the professional and never by a personal visit in all my 30 years.

THE CHAIRMAN: Well, to the available extent?

MR. ZIFKIN: Yes, it has always been by mail and all just goodwill. In hospitals we are now finding our services are being used in the smaller hospitals ---

THE CHAIRMAN: Those which do not maintain a full scale laboratory?

MR. ZIFKIN: No but neither do we.

THE CHAIRMAN: If hospitals do not have this then you provide the service?

MR. ZIFKIN: Yes.

COMMISSIONER FAUTEAUX: I think I saw it here where you mention that there is a provincial laboratory in Ontario and that is located where?

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provincial laboratories?

COMMISSIONER FAUTEAUX: Are they supply that service of specimens to be examined?

MR. ZIFKIN: Actually they are public

health units dealing with epidemic things and who are now going into the field of diagnostics.

COMMISSIONER BALTZAN: Just starting that?

MR. ZIFKIN: They have been doing them for quite a while, I believe.

COMMISSIONER BALTZAN: For years?

MR. ZIFKIN: One of the interesting things, of course, are blood sugars which are done without charge. I do not know of any other place that does it quite like that.

COMMISSIONER BALTZAN: The reason I am asking is because in certain provinces they give an extensive service and there is hardly any limitation but there is a limitation so far in the operation in Ontario, it is not a widespread service, it does not cover ---

MR. ZIFKIN: Yes, complete.

COMMISSIONER BALTZAN: And that is given to patients through doctors submitting the specimen free of charge?

MR. ZIFKIN: No, there is a slight charge.

COMMISSIONER BALTZAN: By whom?

MR. ZIFKIN: By the Department of Health, a very nominal fee to the physician.

COMMISSIONER BALTZAN: In your laboratory do you do bacteriological examinations?

MR. ZIFKIN: No sir, we do nothing that would in any way be in the field of public health.

health units dealing with epidemic cases and who are now going into the field of diagnostics.

COMMISSIONER BALLEM: Just starting

MR. ZIFKIN: They have been doing that for quite a while, I believe.

COMMISSIONER BALLEM: For years?

MR. ZIFKIN: [illegible] in rge, of course, are blood sugars which are done without charge. I do not know of any other place that does it [illegible]

COMMISSIONER BALLEM: The reason I am asking is because in certain provinces they give an outreach service and there is hardly any limitation but there is a limitation so far in the operation in Ontario. It is not a widespread service, it does not [illegible]

MR. ZIFKIN: Yes, [illegible].

COMMISSIONER BALLEM: And there is given to patients through [illegible] the [illegible] of [illegible]?

MR. ZIFKIN: No, there is a [illegible]

MR. ZIFKIN: [illegible] heart, a very [illegible] to the [illegible].

COMMISSIONER BALLEM: In your [illegible] to you do [illegible] [illegible]?

MR. ZIFKIN: No sir, we do nothing that would in any way be in the field of public health.

That is why I say the limitations come into it. Once they are licensed it would be known what that lab does.

COMMISSIONER BALTZAN: Yours is the only one that gives the home service type of service?

MR. ZIFKIN: No sir, there are others.

COMMISSIONER BALTZAN: Thank you.

COMMISSIONER VAN WART: Do you do P.B.I.'s?

COMMISSIONER FIRESTONE: On page 6 of your brief you say:

"There is an increasing tendency for "drug stores to accept body fluid "material for testing and not being "in a position (in almost all cases) "of being capable of doing any analysis."

Are we to understand this paragraph or the sentence to mean that drug stores perform these tests increasingly and they provide inadequate or inferior analyses?

MR. ZIFKIN: I do not think drug stores have registered technicians doing this work.

COMMISSIONER FIRESTONE: That is a statement of fact, I am just interested in the result of such tests as are done by drug stores. Are these, in your opinion, and have you any actual evidence where such analyses was done and it was inadequate and inferior?

MR. ZIFKIN: We have never kept a record of these things but we have had information on being informed about these things and the methodology of doing these things by pharmacists who work in certain

That is what I say the limitations come into it. Once they are licensed it would be known what that lab does.

COMMISSIONER BAUMGAR: Young is the only one that gives the home service type of service?

MR. ZILKIN: No sir, there are others.

COMMISSIONER VAN HART: Do you in

of your brief you say:

"There is an increasing tendency for "young citizens to accept body fluid "samples for testing and not being "in a position (in almost all cases) "of being capable of doing any analysis "are we to understand this takes an "or the sentence to mean that they accept these "tests increasingly and they provide therapists or "laboratory analyses?

MR. ZILKIN: I do not make data available have registered technicians doing this work.

COMMISSIONER VAN HART: That is a statement of fact, I am just interested in the result of such tests is arrived by drug abuse. Are there in your opinion, and have you any actual evidence such analyses was done and it was inadequate and inaccurate?

MR. ZILKIN: We have never had a record of these things but we have had in connection on being informed about these things and the methodology of doing these things by pharmacists working in certain

of these places. I must again say that it is my own experience only, that it was told to me. In the case of an error we know errors can occur but in the following paragraph we also can hint and say we know or it was told to us again by former employees that specimens were actually taken and thrown in the sink and reported.

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of these places. I must again say that it is my own experience only, that it was told to me. In the case of an error we know errors can occur but in the following paragraph we also can hint and say we know or it was told to us again by former employees that specimens were actually taken and thrown in the sink and reported.

/dpw

THE CHAIRMAN: You were told by whom?

MR. ZIFKIN: A previous employee of a drugstore.

THE CHAIRMAN: I don't think we should accept this, with all the publicity of a Commission accepting a lot of hearsay evidence.

MR. ZIFKIN: This is merely hearsay. I made that clear.

THE CHAIRMAN: I don't think we need go into that.

COMMISSIONER FIRESTONE: How do these drugstores get involved? Is it on referral by a physician?

MR. ZIFKIN: This, too, has an historical background. At one time they were permitted to take in all specimens. We did not do any work for drugstores for a number of years until we were approached that perhaps we should do it, at least, this was an approach by one of the inspectors, I think, of the College of Pharmacy.

The law was changed after that, that a drugstore could accept specimens providing a report is given to the doctor. We did work after that. At first we did not accept work because we didn't know where the report was going. After it was approved by their own College that they could accept work and the report went to the doctor, of course, we were not in a position to question whether each patient did have a doctor. However we do know that not all specimens are reported to doctors.

THE CHAIRMAN: You were told by whom?

a dispensary.

and did accept it, with all the publicity of a commission covering a lot of hearsay evidence.

Mr. ZIEKIN: This is merely hearsay.

I made that clear.

THE CHAIRMAN: I don't think we need go into that.

COMMISSIONER HEARTON: How do these dispensaries get involved? Is it on referral by a physician?

Mr. ZIEKIN: This, too, has an historical background. At one time they were permitted to take in all emergencies. We did not do any work for dispensaries for a number of years until we were convinced that perhaps we should do it, at least, this was approved by one of the inspectors, I think, of the College of Pharmacy.

The law has changed after that, that a dispensary could accept emergencies provided a report is given to the doctor. We did work after that. At first we did not accept work because we didn't know where the report was going. After it was approved by their own law that they could accept work and the report went to the doctor, of course, we were not in a position to give them [illegible] upon patients did have a doctor. [illegible] report all emergencies reported to doctors.

COMMISSIONER BALTZAN: You say they could accept specimens. You do not say whether they can perform the test.

MR. ZIFKIN: Accept specimens.

COMMISSIONER BALTZAN: What about performing the test?

MR. ZIFKIN: I suppose the College of Pharmacy could possibly argue that they are chemists.

COMMISSIONER BALTZAN: So that they may even do the test and that is being recognized by their own College.

MR. ZIFKIN: Well, I never asked. I merely ---

COMMISSIONER BALTZAN: I am only asking.

MR. ZIFKIN: These are the little branches of laboratory work which one will have to face in the future. I mean to say, they would be chemists, I suppose, in the eyes of the College of Pharmacy. Our Society, certainly, is doing something to make a stand in this direction.

COMMISSIONER FIRESTONE: You say in the follow-up paragraph on page 6:

> "We feel it would to the best interest of the medical profession and of the patients if such practices by the drugstores were to cease."

If physicians are referring, in some cases, these tests to drugstores, presumably physicians must be satisfied otherwise they wouldn't do it.

COMMISSIONER MATTAWA: Can we say that we could accept assignments. You do not say whether they can perform the task.

MR. ELTKIN: Accept assignments.

COMMISSIONER MATTAWA: Perform the task?

MR. ELTKIN: I suppose the College of Arms would probably argue that they are obligated.

COMMISSIONER MATTAWA: So that they may even do the task and that is being recognized by their own College.

MR. ELTKIN: Well, I never asked.

COMMISSIONER MATTAWA: I am only [illegible].

MR. ELTKIN: These are the little problems of innovator work which one will have to face in the future. I mean to say, they would be [illegible]. I suppose, in the case of the College of Heraldry, the Society, certainly, is doing something to [illegible] stand in our direction.

On the following paragraph on page 6:

"We feel it would be the best interest of the [illegible] [illegible] of the [illegible] [illegible] to cease [illegible]

I [illegible] in [illegible], in some cases, that [illegible] [illegible] [illegible] must be [illegible] [illegible] [illegible] [illegible].

MR. ZIFKIN: Perhaps they know, in some cases, it is being sent to a lab from there. I suppose, too, it is a matter of economics, perhaps, where the thing may be charged to the physician. I don't know. I can only guess. I am assuming this; that he sends the patient or has some charge account between the doctor and the pharmacy and he sends them to the pharmacy. We have often asked patients when they 'phone us for the results - for instance, we had a specimen from a patient, from a drugstore, and it wasn't ready the next morning. The animal had died or something and we found it necessary to repeat the test. The drugstore wouldn't 'phone us but asked the patient to 'phone us and in that way we asked why it was taken to the drugstore, not to a lab. She said she thought all drugstores did these tests. We could have some interesting recordings of our telephone calls with such things that go on.

COMMISSIONER FIRESTONE: Thank you, sir.

THE CHAIRMAN: Thank you, Mr. Zifkin.

We will adjourn to 9.30 tomorrow morning.

--- Adjournment.

[illegible]

[illegible] cases, [illegible] is being sent to a last [illegible] that [illegible] success, too, it is a matter of economics, perhaps, where the [illegible] can be [illegible] to the physician. I really know. I can only guess. [illegible] assuming that that is surely the patient [illegible] some charge account between the doctor and the pharmacy and he sends them to the pharmacy. We have often asked patients when they [illegible] to [illegible] - for instance, we [illegible] a specimen from a patient, from a dermatologic, and it wasn't only the [illegible] working. The animal had lice or something and we found it necessary to repeat the test. The dermatologe wouldn't [illegible] us but asked the patient to [illegible] us and in that way we asked why it was taken to the dermatologe, not to a lab. The said she thought all dermatologe are these [illegible]. We would have some interesting [illegible] if we [illegible] with such things [illegible].

[illegible]

THE CHAIRMAN: Thank you, Mr. [illegible]. We will adjourn to [illegible] tomorrow morning.

--- (Adjourned).